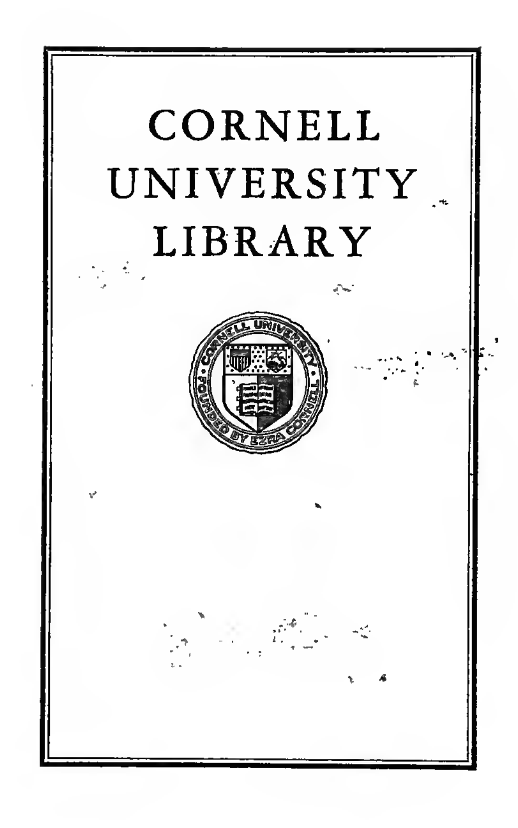



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NERVOUS AND MENTAL DISEASE MONOGRAPH SERIES NO. 4

SELECTED PAPERS ON HYSTERIA

AND

OTHER PSYCHONEUROSES

BY

PROF. SIGMUND FREUD

VIENNA

(SECOND, ENLARGED EDITION)

AUTHORIZED TRANSLATION

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TRANSLATOR'S PREFACE.

In the first place I wish to express my gratitude to Doctors Frederick Peterson, William A. White, and Ernest Jones, for their many helpful suggestions in the translation of this work. This does not, however, imply that they are in any way responsible for the numerous barbarisms found in the translation, for this I, alone, ask the reader's indulgence. For one thing, it must be borne in mind that, aside from the subject-matter, Freud is not easy to read, even in the original. Indeed, I feel quite certain that only those who have read the original will best appreciate the task of the translator. But no matter how devoid of literary excellencies this translation may be, it can at least claim one merit, to wit, it is a faithful reproduction of the author's thoughts. This is really all that should be required of a translation.

The chapters contained in this book were taken from three different volumes of the author's works, published at different intervals within the last fifteen years. Although the first four chapters appear in the "Studien über Hysterie" which was published by Breuer and Freud,[1] still only the first chapter, "The Psychic Mechanism of Hysterical Phenomena," was written conjointly by both authors. The authorship of the other three chapters belongs exclusively to Freud. The remaining six chapters of the book were taken from Freud's Collection of short papers.[2]

It was by no means an easy task to compile in a single limited volume Freud's theories of the actual- and psychoneuroses. Freud's views are not only new and revolutionary, being based on an entirely new psychology, but unless one is thoroughly familiar with their development one is apt to misunderstand them. To obviate this it was thought best to collect those chapters from

[1] Studien über Hysterie von Jos. Breuer und Sigm. Freud. Leipzig und Wien, Franz Deuticke, 1895. 2nd ed., 1909.

[2] Sammlung kleiner Schriften zur Neurosenlehre, Vols. I and II. Leipzig und Wien, Deuticke, 1906, and 1909.

the author's works which fully illustrate his theories and at the same time show the gradual evolution of his psychology.

That Freud's views have undergone some changes, or rather modifications, within the last fifteen years we readily admit; but who will blame the surgeon for modifying or rejecting some technique of his operation, if after years of careful work he feels justified in so doing? Surely such an action merits applause rather than reproach. It was only after carefully investigating for years that Freud saw fit to change some of his views, yet nothing was really totally discarded.

It is quite unnecessary to discuss here the whys and wherefores of the modifications in question, these are fully explained in the text. But it will not be mal à propos to say a few words concerning the technique of the treatment.

For reasons given in the book the author has abandoned hypnotism and used the pressure procedure, but this in turn was given up because it was cumbersome for both doctor and patient and proved to be utterly needless.

The technique is as follows: The patient lies on his back on a lounge, the physician sitting behind the patient's head at the head of the lounge. In this way the patient remains free from all external influences and impressions. The object is to avoid all muscular exertion and distraction, thus allowing thorough concentration of attention on the patient's own psychic activities. The patient is then asked to give a detailed account of his troubles, after having been told before to repeat everything that occurs to his mind, even such thoughts as may cause him embarrassment or mortification. On listening to such a history one invariably notices many memory gaps, both in reference to time and causal relations. These the patient is urged to fill in by concentration of attention on the subject in question, and by repeating all the unintentional thoughts originating in this connection. This is the so-called method of "free association!" The patient is required to relate all his thoughts in the order of their sequence even if they seem irrelevant to him. He must do away with all critique and remain perfectly passive. It is in this way that we fathom the original meaning of the symptom. But as the thoughts which originate in this manner are of a disagreeable and painful nature they are pushed back with the greatest resist-

ance. This is further enhanced by the fact that the hysterical symptom is the symbolic expression of the realization of a repressed wish, and serves as a gratification for the patient. He strives very hard, unconsciously of course, to retain the symptom, as it is the only thing left to him from his former unattainable conscious wishes and strivings. The object of the psychanalytic treatment is to overcome all these resistances, and to reconduct to the patient's consciousness the thoughts underlying the symptoms. Here lies the greatest difficulty, for just as in the normal life and the dream, a psychoneurotic symptom is merely a symbolic or cryptic expression of the original repressed thoughts. Every hysterical symptom, every obsession, and every phobia, has a definite meaning, and as was shown by Bleuler,[3] Jung,[4] Riklin,[5] and others,[6] the same holds true for the psychoses proper.

To discover the hidden mechanism, one must make use of the author's developed method of interpretation, that is, one must look for symbolic actions, lapses in speech, memory, etc., and above all, one must resort to the analysis of dreams, as they give the most direct access to the unconscious. No one is really qualified to use or judge Freud's psychanalytic method who has not thoroughly mastered the Traumdeutung,[7] the Psychopathologie des Alltagsleben,[8] and the Drei Abhandlungen zur Sexualtheorie,[9] and has not had considerable experience in analyzing his own and other's dreams and psychopathological actions. It is especially in the Traumdeutung that Freud has fully developed his psychanalytic technique and a perfect knowledge of which is the

[3] Bleuler, Freudsche Mechanismen in der Symptomatologie der Psychosen, Psychiatrisch-Neurolog Wochenschrift, 1906, Nrs. 35 and 36.

[4] Jung, The Psychology of Dementia Præcox, Nervous and Mental Disease Monograph Series, Nr. 3.

[5] Riklin, Psychiatrisch-Neurolog Wochenschrift, 1905, Nr. 46.

[6] Brill, Psychological Factors in Dementia Præcox, Journal of Abnormal Psychology, Vol. III, Nr. 4, and A Case of Schizophrenia, American Journal of Insanity, Vol. LXVI, No. 1.

[7] Freud, Interpretation of Dreams, transl. by A. A. Brill, The Macmillan Co., N. Y., and George Allen, London.

[8] Freud, Karger, 1907. Translation of this book in preparation.

[9] Three Contributions to the Sexual Theories, transl. by A. A. Brill, Journal Nervous & Mental Dis. Monograph Ser.

sine qua non in the treatment. It is only by following Freud in this manner that one can hope to solve the hitherto unsolved riddles of the psychoneuroses and psychoses.

This treatment is more difficult than one can describe in a preface. It not only presupposes a thorough knowledge of Freud but an equal knowledge of normal and abnormal psychology. Those who have not acquired this knowledge by reason of time or otherwise may remember the words of the younger Pliny: *Ut enim de pictore scalptore fictore nisi artifex iudicare, ita nisi sapiens non potest perspicere sapientem.*

A. A. Brill.

TRANSLATOR'S PREFACE TO SECOND EDITION.

That there should be a demand for a second English edition of this book is very gratifying for many reasons. It not only indicates that we are keeping abreast with Europe where Freud's works are in increasing demand, but it also shows that despite unjust and incompetent critics Freud's ideas are gradually gaining ground in English-speaking countries. The adjective incompetent is advisedly used, for of all the adverse criticism hurled at Freud in this country most of it merits no refutation. The rest can be summed up in the phrase lack of knowledge and experience.

When the first edition of this translation appeared there was hardly any Freudian literature accessible to the English-speaking reader; at present one can gain a fair knowledge of the Freudian theories by studying the numerous writings on the subject.[1] Yet the ignorance evinced by those who are hostile to the Freudian principles and for that matter also by those of his adherents is really surprising. We can well afford to disregard our uninformed opponents, but heaven protect us from our friends who accept everything without knowing what they do. It is those "wild" psychoanalysts that I had in mind when I added to the second edition Freud's effective essay "On Wild Psychoanalysis." The other new chapter, "The Future Chances of Psychoanalytic Therapy," is considered by his pupils one of the most philosophical and appreciative essays of Freud. It gives a broad and comprehensive outline of the general problems of psychoanalysis and directs us to newer fields of investigation. Both chapters serve to show that there is more to psychoanalytic therapy than would seem on reading a few scattered papers.

May this revised and enlarged edition remove some of the hostile prejudices against Freud's theories and help toward further enlightenment on the subject of the neuroses. A. A. BRILL.

[1] Cf. the writings of James J. Putnam, Ernest Jones, William A. White, the present writer and others. We have also translations of the author's Three Contributions to the Sexual Theory (Monograph Series No. 7), The Interpretation of Dreams (The Macmillan Co., N. Y., and George Allen, London), and translations are in preparation of the author's The Psychopathology of Everyday Life, and Wit and Its Relation to the Unconscious.

CHAPTER I.

THE PSYCHIC MECHANISM OF HYSTERICAL PHENOMENA.[1]

(PRELIMINARY COMMUNICATION.)

I.

Instigated by a number of accidental observations we have investigated for a number of years the different forms and symptoms of hysteria in order to discover the cause and the process which provoked the phenomena in question for the first time, in a great many cases years back. In the great majority of cases we did not succeed in elucidating this starting point from the mere history, no matter how detailed it might have been, partly because we had to deal with experiences about which discussion was disagreeable to the patients, but mainly because they really could not recall them; often they had no inkling of the causal connection between the occasioning process and the pathological phenomenon. It was generally necessary to hypnotize the patients and reawaken the memory of that time in which the symptom first appeared, and we thus succeeded in exposing that connection in a most precise and convincing manner.

This method of examination in a great number of cases has furnished us with results which seem to be of theoretical as well as of practical value.

It is of theoretical value because it has shown to us that in the determination of the pathology of hysteria the accidental moment plays a much greater part than is generally known and recognized. It is quite evident that in "traumatic" hysteria it is the accident which evokes the syndrome. Moreover in hysterical crises, if patients state that they hallucinate in each attack the same process which evoked the first attack, here too, the causal connection seems quite clear. The state of affairs is more obscure in the other phenomena.

Our experiences have shown us *that the most varied symptoms*

[1] Written in collaboration with Dr. Joseph Breuer.

which pass as spontaneous, or so to say idiopathic attainments of hysteria, stand in just as stringent connection with the causal trauma as the transparent phenomena mentioned. To such causal moments we were able to refer neuralgias as well as the different kinds of anesthesias often of years' duration, contractures and paralyses, hysterical attacks and epileptiform convulsions which every observer has taken for real epilepsy, petit mal and tic-like affections, persistent vomiting and anorexia, even the refusal of nourishment, all kinds of visual disturbances, constantly recurring visual hallucinations, and similar affections. The disproportion between the hysterical symptoms of years' duration and the former cause is the same as the one we are regularly accustomed to see in the traumatic neurosis. Very often they are experiences of childhood which have established more or less intensive morbid phenomena for all succeeding years.

The connection is often so clear that it is perfectly manifest how the causal event produced just this and no other phenomenon. It is quite clearly determined by the cause. Thus let us take the most banal example; if a painful affect originates while eating but is repressed, it may produce nausea and vomiting and continue for months as a hysterical symptom. A girl was anxiously distressed while watching at a sick bed. She fell into a dreamy state and experienced a frightful hallucination, and at the same time her right arm hanging over the back of a chair became numb. This resulted in a paralysis, contracture, and anesthesia of that arm. She wanted to pray but could find no words, but finally succeeded in uttering an English prayer for children. Later, on developing a very grave and most complicated hysteria, she spoke, wrote, and understood only English, whereas her native tongue was incomprehensible to her for a year and a half. A very sick child finally falls asleep. The mother exerts all her will power to make no noise to awaken it, but just because she resolved to do so she emits a clicking sound with her tongue ("hysterical counter-will"). This was later repeated on another occasion when she wished to be absolutely quiet, developing into a tic which in the form of tongue clicking accompanied every excitement for years. A very intelligent man was present while his brother was anesthetized and his ankylosed hip stretched. At the moment when the joint yielded and crackled he perceived severe pain in his own hip which continued for almost a year.

In other cases the connection is not so simple, there being only as it were a symbolic relation between the cause and the pathological phenomenon, just as in the normal dream. Thus psychic pain may result in neuralgia, or the affect of moral disgust may cause vomiting. We have studied patients who were wont to make the most prolific use of such symbolization. In still other cases such a determination is at first sight incomprehensible, yet to this group belong the typical hysterical symptoms such as hemianesthesia, contraction of visual field, epileptiform convulsions and many others. The explanation of our views on this group we have to reserve for the more detailed discussion of the subject.

Such observations seem to demonstrate the pathogenic analogy between simple hysteria and traumatic neurosis and justify a broader conception of "traumatic hysteria." The active etiological factor in traumatic neurosis is really not the insignificant bodily injury but the affect of the fright, that is, the psychic trauma. In an analogous manner our investigations show that the causes of many, if not of all, cases of hysteria can be designated as psychic traumas. Every experience which produces the painful affect of fear, anxiety, shame or of psychic pain may act as a psychic trauma. Whether an experience becomes of traumatic importance naturally depends on the person affected as well on the determination to be mentioned later. In ordinary hysteria instead of one big trauma we not seldom find many partial traumas, grouped causes which can be of traumatic significance only when summarized and which belong together in so far as they form small fragments of the sorrowful tale. In still other cases apparently indifferent circumstances gain traumatic dignity through their connection with the real effective event or with a period of time of special excitability which they then retain but which otherwise would have no significance.

Nevertheless the causal connection between the provoking psychic trauma and the hysterical phenomena does not perhaps resemble the trauma which as the *agent provocateur* would call forth the symptom which would become independent and continue to exist. We have to claim still more, namely, that the psychic trauma or the memory of the same acts like a foreign body which even long after its penetration must continue to in-

fluence like a new causative factor. The proof of this we see in a most remarkable phenomenon which at the same time gives to our discoveries a distinct practical interest.

We found, at first to our greatest surprise, *that the individual hysterical symptoms immediately disappeared without returning if we succeeded in thoroughly awakening the memories of the causal process with its accompanying affect, and if the patient circumstantially discussed the process giving free play to the affect.* Affectless memories are almost utterly useless. The psychic process originally rebuffed must be reproduced as vividly as possible so as to bring it back into the *statum nascendi* and then be thoroughly "talked over." At the same time if we deal with such exciting manifestations as convulsions, neuralgias and hallucinations they appear once more with their full intensity and then vanish forever. Functional attacks like paralyses and anesthesias likewise disappear, but naturally without any appreciable distinctness of their momentary aggravation.[2]

It is quite reasonable to suspect that one deals here with an unintentional suggestion. The patient expects to be relieved of his suffering and it is this expectation and not the discussion that is the effectual factor. But this is not so. The first observation of this kind in which a most complicated case of hysteria was analyzed and the individual causal symptoms separately abrogated, occurred in the year 1881, that is, in a "pre-suggestive" time. It was brought about through a spontaneous autohypnosis of the patient and caused the examiner the greatest surprise.

In reversing the sentence: *cessante causa cessat effectus,* we may conclude from this observation that the causal process continues to act in some way even after years, not indirectly by means

[2] The possibility of such a therapy was clearly recognized by Delboeuf and Binet, as is shown by the accompanying quotations: Delboeuf, Le magnétisme animal, Paris, 1889: "On s'expliquerait des lors comment le magnétiseur aide à guerison. Il remet le sujet dans l'état oû le mal s'est manifesté et combat par la parole le même mal, mais renaissant." (Binet, Les altérations de la personnalité, 1892, p. 243): ". . . peut-être verra-t-on qu'en reportant le malade par un artifice mental, au moment meme ou le symptome a apparu paur la premiere fois, on rend ce malade plus docile a une suggestion curative." In the interesting book of Janet, L'Automatism Psychologique, Paris, 1889, we find the description of a cure brought about in a hysterical girl by a process similar to our method.

of a chain of causal connecting links but directly as a provoking cause, just perhaps as in the awakened consciousness where the memory of a psychic pain may later call forth tears. *The hysteric suffers mostly from reminiscences.*[3]

II.

It would seem at first rather surprising that long-forgotten experiences should effect so intensively, and that their recollections should not be subject to the decay into which all our memories merge. We will perhaps gain some understanding of these facts by the following examinations.

The blurring or loss of an affect of memory depends on a great many factors. In the first place it is of great consequence whether there was an energetic reaction to the affectful experience or not. By reaction we here understand a whole series of voluntary or involuntary reflexes, from crying to an act of revenge, through which according to experience affects are discharged. If the success of this reaction is of sufficient strength it results in the disappearance of a great part of the affect. Language attests this fact of daily observation, in such expressions as "to give vent to one's feeling," to be "relieved by weeping," etc.

If the reaction is suppressed the affect remains united with the memory. An insult retaliated, be it only in words, is differently recalled than one that had to be taken in silence. Language also recognizes this distinction between the psychic and physical results and designates most characteristically the silently endured suffering as "grievance." The reaction of the person injured to the trauma has really no perfect "cathartic" effect unless it is an adequate reaction like revenge. But man finds a substitute for this action in speech through which help the affect can well nigh be ab-reacted[4] ("abreagirt"). In other cases talking

[3] We are unable to distinguish in this preliminary contribution what there is new in this content and what can be found in such other authors as Moebius and Strümpell who present similar views on hysteria. The greatest similarity to our theoretical and therapeutical accomplishments we accidentally found in some published observations of Benedict which we shall discuss hereafter.

[4] The German abreagiren has no exact English equivalent. It will therefore be rendered throughout the text by "ab-react," the literal meaning

in the form of deploring and giving vent to the torments of the secret (confession) is in itself an adequate reflex. If such reaction does not result through deeds, words, or in the lightest case through weeping, the memory of the occurrence retains above all the affective accentuation.

The ab-reaction (abreagiren), however, is not the only form of discharge at the disposal of the normal psychic mechanism of the healthy person who has experienced a psychic trauma. The memory of the trauma even where it has not been ab-reacted enters into the great complex of the association. It joins the other experiences which are perhaps antagonistic to it and thus undergoes correction through the other ideas. For example, after an accident the memory of the danger and (dimmed) repetition of the fright is accompanied by the recollection of the further course, the rescue, and the consciousness of present security. The memory of a grievance may be corrected by a rectification of the state of affairs by reflecting upon one's own dignity and similar things. Thus the normal person is able to cause a disappearance of the accompanying affect by means of association.

In addition there appears that general blurring of impressions, that fading of memories which we call "forgetting," and which above all wears out the affective ideas no longer active.

It follows from our observations that those memories which become the causes of hysterical phenomena have been preserved for a long time with wonderful freshness and with their perfect emotional tone. As a further striking and a later realizable fact we have to mention that the patients do not perhaps have the same control of these as of their other memories of life. On the contrary, *these experiences are either completely lacking from the memory of the patients in their usual psychic state or at most exist greatly abridged.* Only after the patients are questioned in the hypnotic state do these memories appear with the undiminished vividness of fresh occurrences. Thus one of our patients in a hypnotic state reproduced with hallucinatory vividness throughout half a year all that excited her during an acute

is to react away from or to react off. It has different shades of meaning, from defense reaction to emotional catharsis, which can be discerned from the context.

hysteria on the same days of the preceding year. Her mother's diary which was unknown to the patient proved the faultless accuracy of the reproduction. Another patient, partly in hypnosis and partly in spontaneous attacks, went through with a hallucinatory distinctness all experiences of a hysterical psychosis which she passed through ten years before and for the greatest part of which she was amnesic until its reappearance. She also showed with surprising integrity and sentient force some etiologically important memories of fifteen to twenty-five years' duration which on their return acted with the full affective force of new experiences.

The reason for this we can only find in the fact that in all the aforesaid relations these memories assume an exceptional position in reference to disappearance. *It was really shown that these memories correspond to traumas which were not sufficiently ab-reacted to* ("abreagirt"). On closer investigation of the reasons for this prevention we can find at least two series of determinants through which the reaction to the trauma was discontinued.

To the first group we add those cases in which the patient has not reacted to psychic traumas because the nature of the trauma precluded a reaction as in the case of an irremediable loss of a beloved person or because social relations made the reaction impossible, or because it concerned things which the patient wished to forget and which he therefore intentionally inhibited and repressed from his conscious memory. It is just those painful things which in the hypnotic state are found to be the basis of hysterical phenomena (hysterical delirium of saints, nuns, abstinent women, and well-bred children).

The second series of determinants is not conditioned by the content of the memories but by the psychic states with which the corresponding experiences in the patient have united. As a cause of hysterical symptoms one really finds in hypnosis presentations which are insignificant in themselves but which owe their preservation to the fact that they originated during a severe paralyzing affect like fright or directly in abnormal psychic conditions, as in the semi-hypnotic dreamy states of reveries, in auto-hypnosis and similar states. Here it is the nature of these conditions which makes a reaction to the incident impossible.

To be sure both determinants may unite, and as a matter of fact they often do. This is the case when a trauma in itself effective occurs in a state of a powerful paralyzing affect or in a transformed consciousness. But due to the psychic trauma it may also happen that in many persons one of these abnormal states occurs which in turn makes a reaction impossible.

What is common to both groups of determinants is the fact that those psychic traumas which are not rectified by reaction are also prevented from adjustment by associative elaboration. In the first group it is due to the resolution of the patient who wishes to forget the painful experiences and in this way, if possible, to exclude them from association, and in the second group the associative elaboration does not succeed because there is no productive associative relationship between the normal and pathological state of consciousness in which these presentations originated. We shall soon have occasion to discuss more fully these relationships.

Hence we can say, *that the reason why the pathogenically formed presentations retain their freshness and affective force is because they are not subject to the normal waste through ab-reaction and reproduction in conditions of uninhibited association.*

III.

When we discussed the conditions which, according to our experience, are decisive in the development of hysterical phenomena from psychic traumas, we were forced to speak of abnormal states of consciousness in which such pathogenic presentations originate, and we had to emphasize the fact that the recollection of the effective psychic trauma is not to be found in the normal memory of the patient but in the hypnotized memory. The more we occupied ourselves with these phenomena the more certain became our convictions *that the splitting of consciousness, so striking in the familiar classical cases of double consciousness, exists rudimentarily in every hysteria, and that the tendency to this dissociation, and with it the tendency towards the appearance of abnormal states of consciousness which we comprehend as "hypnoid states," is the chief phenomenon of this neurosis.* In this view we agree with Binet and with both the Janets about

whose most remarkable findings in anesthetics we have had no experience.

Hence, to the often cited axiom, "Hypnosis is artificial hysteria," we would like to add another: "The existence of hypnoid states is the basis and determination of hysteria." These hypnoid states in all their diversities agree among themselves and with hypnosis in the fact that their emerged presentations are very intensive but are excluded from the associative relations of the rest of the content of consciousness. The hypnoid states are associable among themselves, and their ideation may thus attain various high degrees of psychic organization. In other respects the nature of these states and the degree of their exclusiveness differ from the rest of the conscious processes as do the various states in hypnosis, which range from light somnolence to somnambulism, and from perfect memory to absolute amnesia.

If such hypnoid states already exist before the manifested disease they prepare the soil upon which the affect establishes the pathogenic memories and their somatic resulting manifestations. This behavior corresponds to the predisposed hysteria. But the results of our observations show that a severe trauma (like that of a traumatic neurosis) or a painful suppression (perhaps of a sexual affect) may bring about a splitting of presentation groups even in persons otherwise not predisposed. This would then be the mechanism of the psychically acquired hysteria. Between the extremes of these two forms we have to admit a series in which the facility of dissociation in the concerned individuals and the magnitude of the affect of the trauma vary inversely.

We are unable to give anything new concerning the formation of the predisposed hypnoid states. We presume that they often develop from "reveries" very common to the normal for which, for example, the feminine handwork offers so much opportunity. The questions why "the pathological associations" formed in such states are so firm and why they exert a stronger influence on the somatic processes than other presentations, all fall together with the problem of the effectivity of hypnotic suggestions in general. Our experiences in this matter do not show us anything new, on the other hand they throw light on the contradiction between the sentence "Hysteria is a psychosis" and the fact that among hysterics one may meet persons of the clearest

intellects, the strongest wills, greatest principles, and of the subtlest minds. In these cases such characteristics are only true for the waking thought of the person, for in his hypnotic state he is alienated just as we are in the dream. Yet, whereas our dream psychoses do not influence our waking state, the products of hypnotic states project as hysterical phenomena into the waking state.

IV.

Almost the same assertions that we have advanced in reference to the continuous hysterical symptoms we may also repeat concerning hysterical crises. As is known we have Charcot's schematic description of the "major" hysterical attack which when complete shows four phases: (1) The epileptoid, (2) the grand movements, (3) the emotional—*attitudes passionnelles* (hallucinatory phase), and (4) the delirious. By shortening or prolonging the attack and by isolating the individual phases Charcot caused a succession of all those forms of the hysterical attack which are really observed more frequently than the complete *grande attaque.*

Our attempted explanation refers to the third phase, that is the *attitudes passionnelles.* Wherever it is prominent it contains the hallucinatory reproduction of a memory which was significant for the hysterical onset. It is the memory of a grand trauma, the so called χατ'εξοχὴν of traumatic hysteria or of a series of connected partial traumas found at the basis of the common hysteria. Finally the attack may bring back that occurrence which on account of its meeting with a moment of special predisposition was raised to a trauma.

There are also attacks which ostensibly consist only of motor phenomena and lack the passionnelle phase. It is possible during such an attack of general twitching, cataleptic rigidity or an *attaque de sommeil,* to put one's self *en rapport* with the patient, or still better, if one succeeds in evoking the attack in a hypnotic state, it will then be found that here, too, the root of it is the memory of a psychic trauma, or of a series of traumas which make themselves otherwise prominent in an hallucinatory phase. A little girl had suffered for years from attacks of general convulsions which could be and were taken for epileptic. She was

hypnotized for purposes of differential diagnosis and she immediately merged into one of her attacks. On being asked what she saw she said, "The dog, the dog is coming," and it was really found that the first attack of this kind appeared after she was pursued by a mad dog. The success of the therapy then verified our diagnosis.

An official who became hysterical as a result of ill treatment on the part of his employer suffered from attacks, during which he fell to the floor raging furiously without uttering a word or displaying any hallucinations. The attack was provoked in a state of hypnosis and he then stated that he lived through the scene during which his employer insulted him in the street and struck him with a cane. A few days later he came to me complaining that he had the same attack, but this time it was shown in the hypnosis that he went through the scene which was really connected with the onset of his disease; it was the scene in the court room when he was unable to get satisfaction for the ill treatment which he received, etc.

The memories which appear in hysterical attacks or which can be awakened in them correspond in all other respects to the causes which we have found as the basis of the continuous hysterical symptoms. Like these they refer to psychic traumas which were prevented from alleviation by ab-reaction or by associative elaboration, like these they lack entirely or in their essential components the memory possibilities of normal consciousness and appear to belong to the ideation of hypnoid states of consciousness with limited associations. Finally they are also amenable to therapeutic proof. Our observations have often taught us that a memory which has always evoked attacks becomes incapacitated when in a hypnotic state it is brought to reaction and associative correction.

The motor phenomena of the hysterical attack can partly be interpreted as the memory of a general form of reaction of the accompanying affect, or partly as a direct motor expression of this memory (like the fidgeting of the whole body which even infants make use of), and partly, like the hysterical stigmata—the continuous symptoms—they are inexplainable on this assumption.

Of special significance for the hysterical attack is the aforementioned theory, namely, that in hysteria there are presenta-

tion groups which come to light in hypnoid states which are excluded from the rest of the associative process but are associable among themselves, thus representing a more or less highly organized rudimentary second consciousness, a *condition seconde*. A persistent hysterical symptom therefore corresponds to a projection of this second state into a bodily innervation otherwise controlled by the normal consciousness. A hysterical attack gives evidence of a higher organization of this second state, and if of recent origin it signifies a moment in which this hypnoid consciousness gained control of the whole existence, and hence we have an acute hysteria, but if it is a recurrent attack containing a memory we simply have a repetition of the same. Charcot has already given utterance to the fact that the hysterical attack must be the rudiment of a *condition seconde*. During the attack the control of the whole bodily innervation is transferred to the hypnoid consciousness. As familiar experiences show, the normal consciousness is not always repressed, it may even perceive the motor phenomena of the attack while the psychic processes of the same escape its cognizance.

The typical course of a grave hysteria, as everybody knows, is as follows: At first an ideation is formed in the hypnoid state which after sufficient development gains control in a period of "acute hysteria" of the bodily innervation and the existence of the patient thus forming persistent symptoms and attacks, and then with the exception of some remnants there is a recovery. If the normal personality can regain the upper hand, all that survived the hypnoid ideation then returns in hysterical attacks and at times it reproduces, in the personality, states which are again amenable to influences and capable of being affected by traumas. Frequently a sort of equilibrium then results among the psychic groups which are united in the same person; attack and normal life go hand in hand without influencing each other. The attack then comes spontaneously just as memories are wont to come; it may also be provoked just as memories may be by the laws of association. The provocation of the attack results either through stimulating a hysterogenic zone or through a new experience which by similarity recalls the pathogenic experience. We hope to be able to show that there is no essential difference between the apparently two diverse determinants, and that in both cases the hyperesthetic memory is touched. In other cases there

is a great lability of equilibrium, the attack appears as a manifestation of the hypnoid remnant of consciousness as often as the normal person becomes exhausted and incapacitated. We cannot disregard the fact that in such cases the attack becomes denuded of its original significance and may return as a contentless motor reaction.

It remains a task for future investigation to discover what conditions are decisive in determining whether a hysterical individuality should manifest itself in attacks, in persistent symptoms, or in a mingling of both.

V.

We can now understand in what manner the psychotherapeutic method propounded by us exerts its curative effect. *It abrogates the efficacy of the original not ab-reacted presentation of affording an outlet to the strangulated affect through speech. It brings it to associative correction by drawing it into normal consciousness (in mild hypnosis) or it is done away with through the physician's suggestion just as happens in somnambulism with amnesia.*

We maintain that the therapeutic gain obtained by applying this process is quite significant. To be sure we do not cure the hysterical predisposition as we do not block the way for the recurrence of hypnoid states; moreover, in the productive stage of acute hysteria our procedure is unable to prevent the replacement of the carefully abrogated phenomena by new ones. But when this acute stage has run its course and its remnants continue as persistent hysterical symptoms and attacks, our radical method usually removes them forever, and herein it seems to surpass the efficacy of direct suggestion as practiced at present by psychotherapists.

If by disclosing the psychic mechanisms of hysterical phenomena we have taken a step forward on the path so successfully started by Charcot with his explanation and experimental imitation of hystero-traumatic paralysis, we are well aware that in doing this we have only advanced our knowledge in the mechanisms of hysterical symptoms and not in the subjective causes of hysteria. We have but touched upon the etiology of hysteria and could only throw light on the causes of the acquired forms, the significance of the accidental moments in the neurosis.

CHAPTER II.

The Case of Miss Lucy R.

Towards the end of 1892 a friendly colleague recommended to me a young lady whom he had been treating for chronic recurrent purulent rhinitis. It was later found that the obstinacy of her trouble was caused by a caries of the ethmoid. She finally complained of new symptoms which this experienced physician could no longer refer to local affections. She had lost all perception of smell and was almost constantly bothered by one or two subjective sensations of smell. This she found very irksome. In addition to this she was depressed in spirits, weak, and complained of a heavy head, loss of appetite, and an incapacity for work.

This young lady visited me from time to time during my office hours—she was a governess in the family of a factory superintendent living in the suburbs of Vienna. She was an English lady of rather delicate constitution, anemic, and with the exception of her nasal trouble was in good health. Her first statements concurred with those of her physician. She suffered from depression and lassitude, and was tormented by subjective sensations of smell. Of hysterical signs, she showed a quite distinct general analgesia without tactile impairment, the fields of vision showed no narrowing on coarse testing with the hand, the nasal mucous membrane was totally analgesic and reflexless, tactile sensation was absent, and the perception of this organ was abolished for specific as well as for other stimuli, such as ammonia or acetic acid. The purulent nasal catarrh was then in a state of improvement.

On first attempting to understand this case the subjective sensations of smell had to be taken as recurrent hallucinations interpreting persistent hysterical symptoms. The depression was perhaps the affect belonging to the trauma and there must have been an episode during which the present subjective sensations were objective. This episode must have been the trauma, the symbols of which recurred in memory as sensations of smell. Perhaps it would be more correct to consider the recurring

hallucinations of smell with the accompanying depression as equivalents of hysterical attacks. The nature of recurrent hallucinations really makes them unfit to take the part of continuous symptoms, and this really did not occur in this rudimentarily developed case. On the other hand it was absolutely to be expected that the subjective sensations of smell would show such a specialization as to be able to correspond in its origin to a very definite and real object.

This expectation was soon fulfilled, for on being asked what odor troubled her most she stated that it was an odor of burned pastry. I could then assume that the odor of burned pastry really occurred in the traumatic event. It is quite unusual to select sensations of smell as memory symbols of traumas, but it is quite obvious why these were here selected. She was afflicted with purulent rhinitis, hence the nose and its perceptions were in the foreground of her attention. All I knew about the life of the patient was that she took care of two children whose mother died a few years ago from a grave and acute disease.

As a starting point of the analysis I decided to use the "odor of burned pastry." I will now relate the history of this analysis. It could have occurred under more favorable conditions but as a matter of fact what should have taken place in one session was extended over a number of them. She could only visit me during my office hours, during which I could devote to her but little of my time. One single conversation had to be extended for over a week as her duties did not permit her to come to me often from such a distance, so that the conversation was frequently broken off and resumed at the next session.

On attempting to hypnotize Miss Lucy R. she did not merge into the somnambulic state. I therefore was obliged to forego somnambulism and the analysis was made while she was in a state not perhaps differing much from the normal.

I feel obliged to express myself more fully about the point of the technique of my procedure. While visiting the Nancy clinics in 1889 I heard Dr. Liébeault, the old master of hypnotism, say, "Yes, if we had the means to put everybody into the somnambulic state, hypnotism would then be the most powerful therapeutic agent." In Bernheim's clinic it almost seemed that such an art really existed and that it could be learned from Bernheim.

But as soon as I tried to practice it on my own patients I noticed that at least my powers were quite limited in this respect. Whenever a patient did not merge into the somnambulistic state after one to three attempts I possessed no means to force him into it. However, the percentage of somnambulists in my experience were far below that claimed by Bernheim.

Thus I had my choice, either to forbear using the cathartic method in most of the cases suitable for it, or to venture the attempt without somnambulism by using hypnotic influence in light or even doubtful cases. It made no difference of what degree (following the accepted scales of hypnotism) the hypnotism was which did not correspond to somnambulism, for every direction of suggestibility is independent of the other and nothing is prejudicial towards the evocation of catalepsy, automatic movements and similar phenomena for the purpose of facilitating the awakening of forgotten recollections. I soon relinquished the habit of deciding the degree of hypnotism, as in a great number of cases it incited the patients' resistance, and clouded the confidence which I needed for the more important psychic work. Moreover, in mild grades of hypnotism I soon tired of hearing, after the assurance and command, "You will sleep, sleep now!" such protests as, "But, Doctor, I am not sleeping." I was then forced to bring in the very delicate distinction, saying, "I do not mean the usual sleep, I mean the hypnotic,—you see, you are hypnotized, you cannot open your eyes"; or, "I really don't want you to sleep." I, myself, am convinced that many of my colleagues using psychotherapy know how to get out of such difficulties more skilfully than I; they can proceed differently. I, however, believe that if through the use of a word one can so frequently become embarrassed, it is better to avoid the word and the embarrassment. Wherever the first attempt did not produce either somnambulism or a degree of hypnotism with pronounced bodily changes, I dropped the hypnosis and demanded only "concentration," I ordered the patient to lie on his back and close his eyes as a means of reaching this "concentration." With little effort I obtained as profound a degree of hypnotism as was possible.

But inasmuch as I forebore using somnambulism, I perhaps robbed myself of a preliminary stipulation without which the

cathartic method seems inapplicable. For it is based on the fact that in the altered state of consciousness the patients have at their disposal such recollections and recognize such connections which do not apparently exist in their normal conscious state. Wherever the somnambulic broadening of consciousness lacks there must also be an absence of the possibility of bringing about a causal relation which the patient cannot give to the doctor as something known to him, and it is just the pathogenic recollections " which are lacking from the memory of the patients in their usual psychic states or only exist in a most condensed state " (preliminary communication).

My memory helped me out of this embarrassment. I, myself, saw Bernheim adduce proof that the recollections of somnambulism are only manifestly forgotten in the waking state and can be readily reproduced by slight urging accompanied by hand pressure which is supposed to mark another conscious state. He, for instance, imparted to a somnambulist the negative hallucination that he was no more present, and then attempted to make himself noticeable to her by the most manifold and regardless attacks, but was unsuccessful. After the patient was awakened he asked her what he did to her during the time that she thought he was not there. She replied very much astonished, that she knew nothing, but he did not give in, insisting that she would recall everything; and placed his hand on her forehead so that she should recall things, and behold, she finally related all that she did not apparently perceive in the somnambulic state and about which she ostensibly knew nothing in the waking state.

This astonishing and instructive experiment was my model. I decided to proceed on the supposition that my patients knew everything that was of any pathogenic significance, and that all that was necessary was to force them to impart it. When I reached a point where to the question " Since when have you this symptom? " or, " Where does it come from? " I receive the answer, " I really don't know this," I proceeded as follows: I placed my hand on the patient's forehead or took her head between my hands and said, " Under the pressure of my hand it will come into your mind. In the moment that I stop
pressure you will see something before you, or something pass through your mind which you must note. It is that

we are seeking. Well, what have you seen or what came into your mind?"

On applying this method for the first time (it was not in the case of Miss Lucy R.) I was surprised to find just what I wanted, and I may say that it has since hardly ever failed me, it always showed me the way to proceed in my investigations and enabled me to conclude all such analyses without somnambulism. Gradually I became so bold that when a patient would answer, "I see nothing," or "Nothing came into my mind," I insisted that it was impossible. They probably had the right thought but did not believe it and repudiated it. I would repeat the procedure as often as they wished, and every time they saw the same thing. Indeed, I was always right; the patients had not as yet learned to let their criticism rest. They repudiated the emerging recollection or fancy because they considered it as a useless intruding disturbance, but after they imparted it, it was always shown that it was the right one. Occasionally after forcing a communication by pressing the head three or four times I got such answer as, "Yes, I was aware of it the first time, but did not wish to say it," or "I hoped that it would not be this."

By this method it was far more laborious to broaden the alleged narrowed consciousness than by investigating in the somnambulic state, and it made me independent of somnambulism and afforded me an insight into the motives which are frequently decisive for the "forgetting" of recollections. I am in position to assert that this forgetting is often intentional and desired. It is always only manifestly successful.

It appeared to me even more remarkable that apparently long forgotten numbers and dates can be reproduced by a similar process, thus proving an unexpected faithfulness of memory.

The insignificant choice which one has in searching for numbers and dates especially allows us to take to our aid the familiar axiom of the theory of aphasia, namely, that recognition is a slighter accomplishment of memory than spontaneous recollection.

Hence to a patient who is unable to recall in what year, month day a certain event took place, enumerate the years during h it might have occurred as well as the names of the twelve and the thirty-one days of the month, and assure him

that at the right number or name his eyes will open themselves or that he will feel which number is the correct one. In most cases the patients really decide on a definite date and frequently enough (as in the case of Mrs. Cäcilie N.) it could be ascertained from existing notes of that time that the date was correctly recognized. At other times and in different patients it was shown from the connection of the recollected facts that the dates thus found were incontestable. A patient, for instance, after a date was found by enumerating for her the dates, remarked, "This is my father's birthday," and added "Of course I expected this episode [about which we spoke] because it was my father's birthday."

I can only slightly touch upon this theme. The conclusion which I wished to draw from all these experiences is that the pathogenic important experiences with all their concomitant circumstances are faithfully retained in memory, even where they seem forgotten, as when the patient seems unable to recall them.[1]

[1] As an example of the technique mentioned above, that is, of investigating in a non-somnambulic state or where consciousness is not broadened, I will relate a case which I analyzed recently. I treated a woman of thirty-eight who suffered from an anxiety neurosis (agoraphobia, fear of death, etc.). Like many patients of that type she had a disinclination to admit that she acquired this disease in her married state and was quite desirous of referring it back to early youth. She informed me that at the age of seventeen when she was in the street of her small city she had the first attack of vertigo, anxiety, and faintness, and that these attacks recurred at times up to a few years ago when they were replaced by her present disease. I thought that the first attacks of vertigo, in which the anxiety was only blurred, were hysterical and decided to analyze the same. All she knows is that she had the first attack when she went out to make purchases in the main street of her city.—"What purchases did you wish to make?"—"Various things, I believe it was for a ball to which I was invited."—"When was the ball to take place?"—"I believe two days later."—"Something must have happened a few days before this which excited you, and which made an impression on you."—"But I don't know, it is now twenty-one years."—"That does not matter, you will recall it. I will exert some pressure on your head and when I stop it you will either think of or see something which I want you to tell me." I went through this procedure, but she remained quiet.—"Well, has nothing come into your mind?"—"I thought of something, but that can have no connection with it."—"Just say it."—"I thought of a young girl who is dead, but she died when I was eighteen, that is, a year later."—"Let us

After this long but unavoidable digression I now return to the history of Miss Lucy R. As aforesaid, she did not merge into somnambulism when an attempt was made to hypnotize her, but lay calmly in a degree of mild suggestibility, her eyes constantly closed, the features immobile, the limbs without motion. I asked her whether she remembered on what occasion the smell perception of burned pastry originated.—"Oh, yes, I know it well. It was about two months ago, two days before my birthday. I was with the children (two girls) in the school room playing and teaching them to cook, when a letter just left by the letter carrier was brought in. From its postmark and handwriting I recognized it as one sent to me by my mother from Glasgow and I wished to open it and read it. The children then came running over, pulled the letter out of my hand and exclaimed, 'No you must not read it now, it is probably a congratulatory letter for

adhere to this. What was the matter with your friend?"—"Her death affected me very much, because I was very friendly with her. A few weeks before another young girl died, which attracted a great deal of attention in our city, but then I was only seventeen years old."—"You see, I told you that the thought obtained under the pressure of the hands can be relied upon. Well now, can you recall the thought that you had when you became dizzy in the street?"—"There was no thought, it was vertigo."—"That is quite impossible, such conditions are never without accompanying ideas. I will press your head again and you will think of it. Well, what came to your mind?"—"I thought, 'now I am the third.'"—"What do you mean?"—"When I became dizzy I must have thought, now I will die like the other two."—"That was then the idea, during the attack you thought of your friend, her death must have made a great impression on you."—"Yes, indeed, I recall now that I felt dreadful when I heard of her death, to think that I should go to a ball while she lay dead, but I anticipated so much pleasure at the ball and was so occupied with the invitation that I did not wish to think of this sad event." (Notice here the intentional repression from consciousness which caused the reminiscences of her friend to become pathogenic.)

The attack was now in a measure explained, but I still needed the occasional moment which just then provoked this recollection, and accidentally I formed a happy supposition about it.—"Can you recall through which street you passed at that time?"—"Surely, the main street with its old houses, I can see it now."—"And where did your friend live?"—"In the same street. I had just passed her house and was two houses farther when I was seized with the attack."—"Then it was the house which you passed that recalled your dead friend, and the contrast which you then did not wish to think about that again took possession of you."

your birthday and we will keep it for you until then.' While the children were thus playing there was a sudden diffusion of an intense odor. The children forgot the pastry which they were cooking and it became burned. Since then I have been troubled by this odor, it is really always present but is more marked during excitement."

"Do you see this scene distinctly before you?"—"As clearly as I experienced it."—"What was there in it that so excited you?"—"I was touched by the affection which the children displayed towards me."—"But weren't they always so affectionate?"—"Yes, but I just got the letter from my mother."—"I can't understand in what way the affection of the little ones and the letter from the mother contrasted, a thing which you appear to intimate."—"I had the intention of going to my mother and my heart became heavy at the thought of leaving those dear children."—"What is the matter with your mother? Was she so lonesome that she wanted you, or was she sick just then and you expected some news?"—"No, she is delicate but not really sick, and has a companion with her."—"Why then were you obliged to leave the children?"—"This house had become unbearable to me. The housekeeper, the cook, and the French maid seemed to be under the impression that I was too proud for my position.

Still I was not satisfied, perhaps there was something else which provoked or strengthened the hysterical disposition in a hitherto normal girl. My suppositions were directed to the menstrual indisposition as an appropriate moment, and I asked, "Do you know when during that month you had your menses?"—She became indignant: "Do you expect me to know that? I only know that I had them then very rarely and irregularly. When I was seventeen I only had them once."—"Well let us enumerate the days, months, etc., so as to find when it occurred."—She with certainty decided on a month and wavered between two days preceding a date which accompanied a fixed holiday.—Does that in any way correspond with the time of the ball?—She answered quietly: "The ball was on this holiday. And now I recall that I was impressed by the fact that the only menses which I had had during the year occurred just when I had to go to the ball. It was the first invitation to a ball that I had received."

The combination of the events can now be readily constructed and the mechanism of this hysterical attack readily viewed. To be sure the result was gained after painstaking labor. It necessitated on my side full confidence in the technique and individual directing ideas in order to reawaken such details of forgotten experiences after twenty-one years in a sceptical and awakened patient. But then everything agreed.

They united in intriguing against me and told the grandfather of the children all sorts of things about me, and when I complained to both gentlemen I did not receive the support which I expected. I then tendered my resignation to the master (father of the children) but he was very friendly, asking me to reconsider it for two weeks before taking any definite steps. It was while I was in that state of indecision that the incident occurred. I thought that I would leave the house but have remained."—"Aside from the attachment of the children is there anything particular which attracts you to them?"—"Yes, my mother is distantly related to their mother and when the latter was on her death bed I promised her to do my utmost in caring for the children, that I would not forsake them, and be a mother to them, and this promise I broke when offering my resignation."

The analysis of the subjective sensation of smell seemed completed. It was once objective and intimately connected with an experience, a small scene, in which contrary affects conflicted, sorrow at forsaking the children, and the mortification which despite all urged her to this decision. Her mother's letter naturally recalled the motives of this decision because she thought of returning to her mother. The conflict of the affects raised this moment to a trauma and the sensation of smell which was connected with it remained as its symbol. The only thing to be explained was the fact that out of all the sensory perceptions of that scene, the perception of smell was selected as the symbol, but I was already prepared to use the chronic nasal affliction as an explanation. On being directly questioned she stated that just at that time she suffered from a severe coryza and could scarcely smell anything but in her excitement she perceived the odor of burned pastry, it penetrated the organically motived anosmia.

As plausible as this sounded it did not satisfy me; there seemed to be something lacking. There was no acceptable reason wherefore this series of excitements and this conflict of affects should have led to hysteria. Why did it not all remain on a normal psychological basis? In other words, what justified the conversion under discussion? Why did she not recall the scenes themselves instead of the sensations connected with them which she preferred as symbols for her recollection? Such questions might

seem superfluous and impertinent when dealing with old hysterias in whom the mechanism of conversion was habitual, but this girl first acquired hysteria through this trauma, or at least through this slight distress.

From the analysis of similar cases I already knew that where hysteria is to be newly acquired one psychic determinant is indispensable; namely, that some presentation must intentionally be repressed from consciousness and excluded from associative elaboration.

In this intentional repression I also find the reason for the conversion of the sum of excitement, be it partial or total. The sum of excitement which is not to enter into psychic association more readily finds the wrong road to bodily innervation. The reason for the repression itself could only be a disagreeable feeling, the incompatibility of one of the repressible ideas with the ruling presentation-mass of the ego. The repressed presentation then avenges itself by becoming pathogenic.

From this I concluded that Miss Lucy R. merged into that moment of hysterical conversion, which must have been under the determinations of that trauma which she intentionally left in the darkness and which she took pains to forget. On considering her attachment for the children and her sensitiveness towards the other persons of the household, there remained but one interpretation which I was bold enough to impart to her. I told her that I did not believe that all these things were simply due to her affection for the children, but that I thought that she was rather in love with her master, perhaps unwittingly, that she really nurtured the hope of taking the place of the mother, and it was for that reason that she became so sensitive towards the servants with whom she had lived peacefully for years. She feared lest they would notice something of her hope and scoff at her.

She answered in her laconic manner: "Yes, I believe it is so." —"But if you knew that you were in love with the master, why did you not tell me so?"—"But I did not know it, or rather, I did not wish to know it. I wished to crowd it out of my mind, never to think of it, and of late I have been successful."[2]

[2] A better description of this peculiar state in which one knows something and at the same time does not know it, I could never obtain. It can apparently be understood only if one has found himself in such a

"Why did you not wish to admit it to yourself? Were you ashamed because you loved a man?"—"O, no, I am not unreasonably prudish; one is certainly not responsible for one's own feelings. I only felt chagrined because it was my employer in whose service I was and in whose house I lived, and toward whom I could not feel as independent as towards another. What is more, I am a poor girl and he is a rich man of a prominent family, and if anybody should have had any inkling about my feelings they would have ridiculed me."

After this I encountered no resistances in elucidating the origin of this affection. She told me that the first years of her life in that house were passed uneventfully. She fulfilled her duties without thinking about unrealizable wishes. One day, however, the serious, and very busy and hitherto very reserved master, engaged her in conversation about the exigencies of rearing the children. He became milder and more cordial than usual, he told her how much he counted on her in the bringing up of his orphaned children, and looked at her rather peculiarly. It was in this moment that she began to love him, and gladly occupied herself with the pleasing hopes which she conceived during that conversation. However, as this was not followed by anything else, and despite her waiting and persevering no other confidential heart-to-heart talk followed, she decided to crowd it out of her mind. She quite agreed with me that the look in connection with the conversation was probably intended for the memory of his deceased wife. She was also perfectly convinced that her love was hopeless.

After this conversation I expected a decided change in her condition but for a time it did not take place. She continued de-

state. I have at my disposal a very striking recollection of this kind which I can vividly see. If I make the effort to recall what passed through my mind at that time my output seems very poor. I saw at that time something which was not at all appropriate to my expectations, and what I saw did not in the least divert me from my definite purpose, whereas this perception ought to have done away with my purpose. I did not become conscious of this contradiction nor did I remark the affect of the repulsion to which it was undoubtedly due that this perception did not attain any psychic validity. I was struck with that form of blindness in seeing eyes, which one admires so much in mothers towards their daughters, in husbands towards their wives, and in rulers towards their favorites.

pressed and moody—a course of hydrotherapy which I ordered for her at the same time refreshed her somewhat mornings. The odor of burned pastry did not entirely disappear; though it became rarer and feebler it appeared only, as she said, when she was very much excited.

The continuation of this memory symbol led me to believe that besides the principal scene it represented many smaller side traumas and I therefore investigated everything that might have been in any way connected with the scene of the burned pastry. We thus passed through the theme of family friction, the behavior of the grandfather and others, and with that the sensation of burned odor gradually disappeared. Just then there was a lengthy interruption occasioned by a new nasal affliction which led to the discovery of the caries of the ethmoid.

On her return she informed me that she received many Christmas presents from both gentlemen as well as from the household servants, as if they were trying to appease her and wipe away the recollection of the conflicts of the last months. These frank advances made no impression on her.

On questioning her on another occasion about the odor of burned pastry she stated that it had entirely disappeared, but instead she was now bothered by another and similar odor like the smoke of a cigar. This odor really existed before; it was only concealed by the odor of the pastry but now appeared by itself.

I was not very much pleased with the success of my treatment. What occurred here is what a mere symptomatic treatment is generally blamed for, namely, that it removes one symptom only to make room for another. Nevertheless, I immediately set forth to remove this new memory symbol by analysis.

This time I did not know whence this subjective sensation of smell originated, nor on what important occasion it was objective. On being questioned she said, "They constantly smoke at home, I really don't know whether the smell which I feel has any particular significance." I then proposed that she should try to recall things under the pressure of my hands. I have already mentioned that her recollections were plastically vivid, that she was a "visual." Indeed under the pressure of my hands a picture came into her mind—at first only slowly and fragmen-

tarily. It was the dining room of the house in which she waited with the children for the arrival of the gentlemen from the factory for dinner.—"Now we are all at the table, the gentlemen, the French maid, the housekeeper, the children and I. It is the same as usual."—"Just keep on looking at that picture. It will soon become developed and specialized."—"Yes, there is a guest, the chief accountant, an old gentleman who loves the children like his own grandchildren, but he dines with us so frequently that it is nothing unusual."—"Just have patience, keep on looking at the picture, something will certainly happen."—"Nothing happens. We leave the table, the children take leave and go with us up to the second floor as usual."—"Well?"—"It really is something unusual, I now recognize the scene. As the children take leave the chief accountant attempts to kiss them, but my master jumps up and shouts at him, 'Don't kiss the children!' I then experienced a stitch in the heart, and as the gentlemen were smoking, this odor remained in my memory."

This, therefore, was the second, deeper seated scene causing the trauma and leaving the memory symbol. But why was this scene so effective? I then asked her which scene happened first, this one or the one with the burned pastry?—"The last scene happened first by almost two months."—"Why did you feel the stitch at the father's interference? The reproof was not meant for you."—"It was really not right to rebuke an old gentleman in such manner who was a dear friend and a guest; it could have been said quietly."—"Then you were really affected by your master's impetuosity? Were you perhaps ashamed of him, or have you thought, 'If he could become so impetuous to an old friend guest over such a trifle, how would he act towards me if I were his wife?'"—"No, that is not it."—"But still it was about his impetuosity?"—"Yes, about the kissing of the children; he never liked that." Under the pressure of my hands there emerged a still older scene which was the real effective trauma and which bestowed on the scene with the chief accountant the traumatic effectivity.

A few months before a lady friend visited the house and on leaving kissed both children on the lips. The father, who was present, controlled himself and said nothing to the lady, but when she left he was very angry at the unfortunate governess.

He said that he held her responsible for this kissing; that it was her duty not to tolerate it; that she was neglecting her duties in allowing such things, and that if it ever happened again he would entrust the education of his children to some one else. This occurred while she believed herself loved and waited for a repetition of that serious and friendly talk. This episode shattered all her hopes. She thought: "If he can upbraid and threaten me on account of such a trifle, of which I am entirely innocent, I must have been mistaken, he never entertained any tenderer feelings towards me, else he would have been considerate."—It was evidently this painful scene that came to her as the father reprimanded the chief accountant for attempting to kiss the children.

On being visited by Miss Lucy R. two days after the last analysis I had to ask her what pleasant things happened to her. She looked as though transformed, she smiled and held her head aloft. For a moment I thought that after all I probably mistook the conditions and that the governess of the children had now become the bride of the master. But she soon dissipated all my suppositions, saying, "Nothing new happened. You really do not know me. You have always seen me while I was sick and depressed. I am otherwise always cheerful. On awaking yesterday morning my burden was gone and since then I feel well." —"What do you think of your chances in the house?"—"I am perfectly clear about that. I know that I have none, and I am not going to be unhappy about it."—"Will you now be able to get along with the others in the house?"—"I believe so, because most of the trouble was due to my sensitiveness."—"Do you still love the master?"—"Certainly I love him, but that does not bother me much. One can think and feel as one wishes."

I now examined her nose and found that the pain and the reflex sensations had almost completely reappeared. She could distinguish odors, but she was uncertain when they were very intense. What part the nasal trouble played in the anosmia I must leave undecided.

The whole treatment extended over a period of nine weeks. Four months later I accidentally met the patient at one of our summer resorts—she was cheerful and stated that her health continued to be good.

Epicrisis.

I would not underestimate the aforesaid case even though it only represents a young and light hysteria presenting but few symptoms. Moreover, it seems to me instructive that even such a slight neurotic affliction requires so many psychic determinants, and on a more exhaustive consideration of this history I am tempted to put it down as an illustration of that form of hysteria which even persons not burdened by heredity may acquire if their experiences favor it. It should be well noted that I do not speak of a hysteria which may be independent of all predisposition; such form does not probably exist, but we speak of such a predisposition only after the person became hysterical, as nothing pointed to it before this. A neuropathic disposition as commonly understood is something different. It is determined even before the disease by a number of hereditary burdens, or a sum of individual psychic abnormalities. As far as I know none of these moments could be demonstrated in the case of Miss Lucy R. Her hysteria could therefore be called acquired and presupposes nothing except probably a very marked susceptibility to acquire hysteria, a characteristic about which we know hardly anything. The chief importance in such cases lies in the nature of the trauma, to be sure in connection with the reaction of the person to the trauma. It is an indispensable condition for the acquirement of hysteria that there should arise a relation of incompatibility between the ego and some of its approaching presentations. I hope to be able to show in another place how a variety of neurotic disturbances originate from the different procedures which the "ego" pursues in order to free itself from that incompatibility. The hysterical form of defence, for which a special adaptation is required, consists in converting the excitement into physical innervation. The gain brought about by this process is the crowding out of the unbearable presentation from the ego consciousness, which then contains instead the physical reminiscences produced by conversion—in our case the subjective sensation of smell—and suffers from the affect which is more or less distinctly adherent to these reminiscences. The situation thus produced is no longer changeable, for changing and conversion annihilate the conflict which helped towards the adjustment of the affect. Thus

the mechanism producing hysteria corresponds on the one hand to an act of moral faint heartedness; on the other hand it presents itself as a protective arrangement at the command of the ego. There are many cases in which it must be admitted that the defense of the increased excitement through the production of hysteria may actually have been most expedient, but more frequently one will naturally come to the conclusion that a greater measure of moral courage would have been an advantage to the individual.

Accordingly the real traumatic moment is that in which the conflict thrusts itself upon the ego and the latter decides to banish it. Such banishment does not annihilate the opposing presentation but merely crowds it into the unconscious. This process, occurring for the first time, forms a nucleus and point of crystallization for the formation of a new psychic group separated from the ego, around which, in the course of time, everything collects in accord with the opposing presentation. The splitting of consciousness in such cases of acquired hysteria is thus a desired and intentional one, and is often initiated by at least one arbitrary act. But literally, something different happens than the individual expects, he would wish to eliminate a presentation as though it never came to pass but only succeeds in isolating it psychically.

The traumatic moment in the history of our patient corresponds to the scene created by the master on account of the kissing of the children. For the time being this scene remained without any palpable effects; perhaps it initiated the depression and sensitiveness, but I leave this open;—the hysterical symptoms, however, commenced later in moments which can be designated as "auxiliary," and which may be characterized by the fact that in them there is a simultaneous flowing together of both separated groups just as in the broadened somnambulic consciousness. The first of these moments in which the conversion took place in Miss Lucy R., was the scene at the table when the chief accountant attempted to kiss the children. The traumatic memory helped along, and she acted as though she had not entirely banished her attachment for her master. In other cases we find that these different moments come together and the conversion occurs directly under the influence of the trauma.

The second auxiliary moment repeated almost precisely the

mechanism of the first. A strong impression transitorily re-established the unity of consciousness and the conversion takes the same route opened to it in the first. It is interesting to note that the symptom occurring second concealed the first so that it could not be distinctly perceived until the second was eliminated. The reversal of the succession of events to which also the analysis must be adapted seems to me quite remarkable. In a whole series of cases I found that the symptoms which came later covered the first, and only the last thing in the analysis contained the key to the whole.

The therapy here consisted in forcing the union of the dissociated psychic groups with the ego consciousness. It is remarkable that the success did not run parallel with the accomplished work, the cure resulted suddenly only after the last part was accomplished.

CHAPTER III.

THE CASE OF MISS ELISABETH V. R.

In the fall of 1892 I was requested by a friendly colleague to examine a young lady who had suffered from pains in her legs for over two years and who walked badly. He also added that he diagnosed the case as hysteria, though none of the usual symptoms of the neurosis could be found. He stated that he knew something of the family and that the last few years had brought them much misfortune and little pleasure. At first the father of the patient died, then the mother underwent a serious operation for the eyes, and soon thereafter a married sister succumbed to a chronic cardiac affection after childbirth. Our patient had taken an active part in all the afflictions and in all the nursings of the sick. I made no further progress into the case after I had seen the twenty-four-year-old patient for the first time. She seemed intelligent and psychically normal and her affliction, which interfered with her social relations and pleasure, she bore with a happy mien, thus vividly recalling the "belle indifference" of hysterics. She walked with the upper part of her body bent forward, but without any support; her gait did not correspond to any known pathological gait and it was in no way strikingly bad. She complained of severe pains on walking, of early fatigue in walking as well as standing, and after a brief period she would seek rest in which the pains became diminished but they by no means disappeared. The pain was of an indefinite nature—one could assume it to be a painful fatigue. The seat of the pain was given as a quite extensive but indefinitely circumscribed location on the superficial surface of the right thigh. It was from this area that the pains radiated and where they were of the greatest intensity. Here, too, the skin and muscles were especially sensitive to pressure and pinching, while needle pricks were rather indifferently perceived. The same hyperalgesia of the skin and muscles was demonstrable, not only in this area, but over almost the entire surface of both legs. The muscles were perhaps more painful than the skin, but both kinds of pains were unmistakably most pro-

nounced over the thighs. The motor power of the legs was not diminished, the reflexes were of average intensity and all other symptoms were lacking, so that there was no basis for the assumption of a serious organic affection. The disease developed gradually during two years and changed considerably in its intensity.

I did not find it easy to determine the diagnosis, but for two reasons I concluded to agree with my colleague. First, because it was rather peculiar that such a highly intelligent patient should not be able to give anything definite about the character of her pains. A patient suffering from an organic pain, if it is not accompanied by any nervousness, will be able to describe it definitely and calmly; it may perhaps be lancinating, appearing at certain intervals, extending from this to that location, and in his opinion it may be evoked by this or that influence. The neurasthenic describing his pain gives the impression of being occupied with some difficult mental problem reaching far beyond his powers. His features are tense and distorted as though under the domination of a painful affect, his voice becomes shriller, he struggles for expression, he rejects all designations that the physician makes for his pains, even though they are undoubtedly afterwards found as appropriate. He is ostensibly of the opinion that language is too poor to give expression to his feelings. His sensations are something unique, they never existed before so that they can not be exhaustively described. He never tires of constantly adding new details and when he has to stop he is surely controlled by the impression that he was unsuccessful in making himself understood to the physician. All this is due to the fact that his pains absorb his whole attention. In the case of Miss v. R. we had just the opposite behavior and we had to conclude from this that she attributed sufficient significance to the pain, but that her attention was concentrated on something else of which the pains were the accompanying phenomena, perhaps on thoughts and sensations which were connected with the pain.

A still greater determination for the conception of the pain must, however, be found in a second moment. If we irritate a painful area in a patient suffering from an organic disease or neurasthenia his physiognomy will show a definite expression of discomfort or of physical pain. Furthermore, the patient winces,

refuses to be examined and assumes a defensive attitude. With Miss v. R. when the hyperalgesic skin or muscles of her legs were pinched or pressed her face assumed a peculiar expression approaching nearer pleasure than pain, she cried out and—I had to think of a pleasurable tickling—her face reddened, she threw her head backward, closed her eyes, and her body bent backward; all this was not very distinct but sufficiently marked so that it could only agree with the conception that her affliction was a hysteria and that the irritation touched a hysterogenic zone.

Her mien was not in accord with the pain which the pinching of the muscles and skin were supposed to excite. It probably harmonized better with the content of the thoughts which were behind the pain and which were evoked in the patient by irritating that part of the body associated with them. I have repeatedly observed similar significant expressions on irritating hyperalgesic zones in unmistakable cases of hysteria. The other gestures evidently corresponded to the slightest indications of a hysterical attack.

We could not at that time find any explanation for the unusual localization of the hysterogenic zone. That the hyperalgesia chiefly concerned the muscles gave material for reflection. The most frequent affliction causing the diffuse and local pressure sensitiveness of the muscles is the rheumatic infiltration of the same, the common chronic muscular rheumatism about which aptitude to mask nervous affections I have already spoken. The consistency of the painful muscles in Miss v. R. did not contradict this assumption, as there were many hard cords in the muscle masses which seemed to be especially sensitive. There was probably also an organic change in the muscles, in the assumed sense, upon which the neurosis rested and which significance was markedly exaggerated by the neurosis.

The therapy followed out was based on a supposition of a mixed affection. We recommended the continuation of a systematic massage and faradization of the sensitive muscles without regard to the pain produced, and in order to remain in communication with the patient I undertook the treatment of her legs by means of strong Franklin's sparks. To her question whether she should force herself to walk we answered decidedly in the affirmative.

We thus attained a slight improvement. She particularly liked the painful shocks of the influence machine and the stronger they were the more they seemed to suppress her pains. My colleague meanwhile prepared the soil for the psychic treatment, and when after four weeks of sham treatment I proposed the same and gave the patient some explanations concerning the procedures and its effects I found a ready understanding and only slight resistances.

The work which then began became eventually the most arduous that ever befell my lot, and the difficulty of giving an account of this work ranks well with the obstacles that had to be overcome. For a long time, too, I did not understand the connection between the history of the disease and the affliction, a thing which should really have been caused and determined by this row of events.

When one undertakes a cathartic treatment he at first asks himself whether the patient understands the origin and cause of her suffering. If that is so one does not need any special technique to cause her to reproduce the history of her ailment. The interest shown in her, the understanding which we foreshadow, the hope of recovery extended to her, all these will induce the patient to give up her secrets. With Miss Elisabeth it seemed probable to me right from the very beginning that she was conscious of the reasons for her suffering, that she had only a secret but no foreign body in consciousness. On looking at her one had to think of the poet's words,

"That mask indicates a hidden meaning."[1]

At first I could thus forego hypnosis, reserving it, however, for future use if in the course of the confession conditions should arise for which explanation the memory would not perhaps suffice. Thus in this first complete analysis of a hysteria which I had undertaken, I reached a process of treatment which later I raised into a method and employed it consciously in the process of removing by strata the pathogenic psychic material which we used to compare with the technique of excavating a buried city. I at first allowed the patient to relate to me what was known to her, paying careful attention wherever a connection remained enigmatical or where a link in the chain of causation seemed to be

[1] It will be shown that, notwithstanding, I erred.

lacking. Later I penetrated into the deeper strata of memory by using for those locations hypnotic investigation or a similar technique. The presupposition of the whole work was naturally the expectation that a perfect and sufficient determination could be demonstrated. The means of the deeper investigation will soon be discussed.

The history which Miss Elisabeth gave was very dull and was woven of manifold painful experiences. During this recital she was not in a hypnotic state; I merely asked her to lie down and keep her eyes closed. I however made no objection if she from time to time opened her eyes, changed her position or sat up. Whenever she entered more deeply into a part of her history she seemed to merge spontaneously into a condition resembling a hypnotic state. She then remained motionless and kept her eyes firmly closed.

I shall now reproduce the results of the superficial strata of her memory. As the youngest of three daughters she spent her youth with her parents, to whom she was devotedly attached, on their estate in Hungary. Her mother's health was frequently disturbed by an affliction of her eyes and also by nervous conditions. It thus happened that she became especially and devotedly attached to her jovial and broadminded father who was wont to say that this daughter took the place of both a son and friend with whom he could exchange his thoughts. As much as the girl gained in mental stimulation in consequence of this intercourse it did not escape the father that her psychic constitution deviated from that ideal which one so much desires to see in a girl. Jocosely he called her pert and disputatious. He warned her against being too confident in her judgments, against her tendencies to tell the truth regardlessly to everybody and expressed his opinion that she would find it difficult to get a husband. As a matter of fact she was very discontented with her girlhood; she was filled with ambitious plans, wishing to study or obtain a musical education, and revolted at the thought of being forced to give up her inclination to sacrifice her freedom of judgment on account of marriage. Meanwhile she was proud of her father, of the regard and social position of her family, and jealously guarded everything connected with these matters. The indifference with which she treated her mother and older sisters, as will

be shown, was considered by her parents to be due to the blunter side of her character.

The age of the girls impelled the family to move into the metropolis, where for a time Elisabeth enjoyed the richer and gayer life. But then came the calamity which destroyed the happiness of the home. The father either concealed or overlooked a chronic cardiac affection, and one day he was brought home in an unconscious state after the first attack of edema of the lungs. This was followed by an illness of one and a half years, during which Elisabeth took the most prominent part in nursing him. She slept in her father's room, awoke at night at his call, watched over him faithfully during the day, and forced herself to appear cheerful while he went through a hopeless condition with amiable resignation. The beginning of her affection must have been connected with this time of her nursing, for she could recall that during the last half year of this care she had to remain in bed on one occasion for a day and a half on account of severe pain in the leg. She maintained, however, that these pains soon passed away and excited neither worry nor attention. As a matter of fact it was two years after the death of her father that she began to feel sick and became unable to walk on account of pain.

The gap which the father left in the life of this family consisting of four women, the social solitude, the cessation of so many relations which promised stimulation and pleasure, the increased infirmity of the mother, all these clouded the mood of our patient, but simultaneously stimulated a warm desire that the family might soon find a substitute for the lost happiness and urged her to concentrate her entire devotion and care on the surviving mother. At the end of the mourning year the eldest sister married a talented and ambitious man of notable position, who by his mental capacity seemed to be destined for a great future, but who, however, very soon developed a morbid sensitiveness and egotistic perseveration of moods, and dared to show his disregard for the old lady in the family circle. That was more than Elisabeth could endure. She felt herself called upon to take up the fight against her brother-in-law whenever he gave occasion for it, while the other women took lightly the outburst of his excited temperament. To her it was a painful disillusionment to find that the reconstruction of the old family happiness experienced such

a disturbance. She could not forgive her married sister because with feminine docility she strove to avoid espousing her cause. Thus a whole series of scenes remained in Elisabeth's memory to which were attached a number of partially uttered grievances against her first brother-in-law. But what she reproached him most for was the fact that for the sake of a promotion in view he moved with his small family to a distant city in Austria and thus increased the lonesomeness of her mother. On this occasion Elisabeth distinctly felt her inability and helplessness to afford her mother a substitute for the lost happiness, and the impossibility of following out the resolution made at the death of her father.

The marriage of the second sister seemed to promise more for the future of the family. The second brother-in-law, although not of the same mental calibre as the first, was a man after the heart of delicate ladies, and his behavior reconciled Elisabeth to the matrimonial institution and to the thought of the sacrifice connected with it. What is more the second couple remained near her mother, and the child of this brother-in-law and the second sister became Elisabeth's pet. Unfortunately the year during which the child was born was clouded by another event. The visual affliction of the mother demanded many weeks' treatment in a dark room, in which Elisabeth participated. Following this an operation proved necessary and the excitement connected with this occurred at the same time that the first brother-in-law made preparations to move. Finally the operation, skilfully performed, proved successful, and the three families met at a summer resort. There Elisabeth, exhausted by the worries of the past months, had the first opportunity to recuperate from the effects of the suffering and anxiety that the family had undergone since the death of her father.

But during the time spent at this resort Elisabeth was attacked by the pain and weakness. Afterwards, the pains, which had become noticeable for a short while some time previously, manifested themselves severely for the first time after taking a warm bath at a small watering place. In connection with this it was thought that a long walk, really a walk of half a day, a few days previously, had some connection with the onset of the pains. This readily produced the impression that Elisabeth at first became "fatigued" and then "caught cold."

From this time on Elisabeth became the patient in the family. Following the advice of the physician she spent the rest of the summer in the watering place at Gastein, whither she went with her mother, but not without having a new worriment to think about. The second sister was again pregnant and information as to her condition was quite unfavorable, so that Elisabeth could hardly decide to take the journey to Gastein. After barely two weeks at Gastein both mother and sister were recalled as the patient at home did not feel well.

An agonizing journey, which for Elisabeth was a mixture of pain and anxious expectations, was followed by certain signs at the home railroad station which forebode the worst, and then on entering the chamber of the patient they were confronted with the reality—that they arrived too late to take leave of the dying one.

Elisabeth not only suffered from the loss of this sister whom she dearly loved but was also grieved by the thoughts caused by her death and the changes which it caused. The sister had succumbed to heart trouble which was aggravated by the pregnancy.

She then conceived the thought that the heart trouble was the paternal inheritance. It was then recalled that in her early childhood the deceased went through an attack of chorea with a slight heart affection. The family then blamed themselves and the physicians for permitting the marriage. They could not spare reproaches to the unfortunate widower for impairing the health of his wife by two successive pregnancies without any pause. The sad thought that this happiness should terminate thus after the rare conditions for a happy marriage had been found, thereafter constantly occupied Elisabeth's mind. Moreover, she again saw everything fail that she had planned for her mother. The widowed brother-in-law was inconsolable and withdrew from his wife's family. It seemed that his own family from whom he was estranged during his short and happy married life took advantage of the opportunity to again draw him into their own circle. There was no way of maintaining the former union; to live together with the mother-in-law was improper out of regard for the unmarried sister-in-law, and inasmuch as he refused to relinquish the child, the only legacy of the deceased, to the two ladies, he for the first time gave them the opportunity of accus-

ing him of heartlessness. Finally, and that was not the least painful thing, Elisabeth received some indefinite information concerning a disagreement between the two brothers-in-law, the occasion for which she could only surmise. It seemed as if the widower made some requests concerning financial matters which the other brother-in-law considered unjustifiable, and thought, that in view of the recent sorrow of his mother, it was nothing but an evil extortion. This then was the history of the young woman of ambitious and loving disposition. Resentful of her fate, embittered over the failures of her little plans to restore the lustre of the home; of her beloved ones, some being dead, some away, and some estranged—without any inclination to seek refuge in the love of a strange man, she lived thus for a year and a half nursing her mother and her pains, separated from almost all social intercourse.

If we forget the greater sufferings and place ourselves in this girl's position, we can but extend to Miss Elisabeth our hearty sympathy. But what is the physician's interest in this sorrowful tale; what is its relation to her painful and her weak gait; what outlook is there for explaining and curing this case by the knowledge which we perhaps obtained from these psychic traumas?

For the physician this confession of the patient signified at first a great disappointment, for to be sure it was a history composed of banal mental shocks from which we could neither explain why the patient became afflicted with hysteria nor how the hysteria assumed the form of the painful abasia. It explained neither the causation nor the determination of the hysteria in question. We could perhaps assume that the patient had formed an association between her psychically painful impressions and bodily pains which she accidentally perceived simultaneously, and that now she made use in her memory of the physical sensation as a symbol for the psychic. What motive she had for this substitution and in what moment this came about remained unexplained. To be sure, these were questions whose nature was not familiar to the physicians. For it was customary to content one's self with the information and to assume that the patient was constitutionally hysterical and that under the inten-

sive pressure of any kind of excitement hysterical symptoms could develop.

Even less than for the explanation did this confession offer for the treatment of the case. One could not conceive what beneficial influence Miss Elisabeth could derive from recounting sad familiar family experiences of the past years to a stranger who could give her in return only moderate sympathy, nor could we perceive any improvement after the confession. During the first period of the treatment the patient never failed to repeat to her physician: " I continue to feel ill, I have the same pains as before," and when she accompanied this by a crafty and malicious glance, I could perhaps recall the words which old Mr. v. R. was wont to utter concerning his favorite daughter: "She is frequently pert and disputatious," but after all I had to confess that she was right.

Had I given up the patient at this stage of the psychic treatment the case of Miss Elisabeth v. R. would have been quite unimportant for the theory of hysteria. Nevertheless, I continued my analysis because I felt sure that an understanding of the causation as well as the determination of the hysterical symptoms could be gained from the deeper strata of consciousness.

I therefore decided to put the direct question to the broadened consciousness of the patient, in order to find out with what psychic impression the origin of the pain in the legs was connected.

For this purpose the patient should have been put in deep hypnosis. But unhappily I had to realize that all my procedures in that direction could put the patient in no other state of consciousness than that in which she gave me her confession. Still I was very pleased that this time she abstained from triumphantly remonstrating with the words: "You see I really do not sleep, I cannot be hypnotized." In such despair I conceived the idea of making use of the trick of pressing the head, the origin of which I have thoroughly discussed in the preceding contribution concerning Miss Lucy. This was done by requesting the patient to unfailingly inform me of what came before her mind's eye or passed through her memory at the moment of the pressure. For a long time she was silent, and then admitted that on my pressure she thought of an evening in which a young man had

accompanied her home from some social affair. She also thought of the conversation that passed between them, and her feelings on returning home to nurse her father.

With this first mention of the young man a new shaft was opened, the content of which I now gradually brought out. We dealt here rather with a secret, for with the exception of a mutual friend, no one knew anything of the relation and the hopes connected with it. It concerned the son of an old friend who was formerly one of their neighbors. The young man having become an orphan attached himself with great devotion to her father; he was guided in his career by his advice, and this veneration for the father was extended to the ladies of the family. Numerous reminiscences of repeated joint readings, exchange of thoughts and utterances on his side marked the gradual growth of her conviction that he loved and understood her and that a marriage with him would not impose the sacrifice that she feared. Unhappily he was but little older than she and as yet was far from being independent. She however firmly resolved to wait for him.

With the serious illness of her father, and the necessity of her nursing him their relations became less frequent. The evening which she at first recalled marked the height of her feeling but even then there was no exchange of ideas between them on the subject. It was only at the urging of her family that she consented to leave the sick bed that evening and go to an affair where she was to meet him. She wished to hasten home early but was forced to remain, only yielding on his promising to accompany her home. At no time had she entertained such a tender regard for him as during this walk, but after returning home at a late hour in this blissful state and finding the condition of her father aggravated she bitterly reproached herself for having sacrificed so much time for her own amusement. It was the last time that she left her sick father for a whole evening; her friend she saw but seldom after this. After the death of her father he seemed to hold himself aloof out of respect for her sorrow and then business affairs drew him into other spheres. Gradually she came to the realization that his interest in her was suppressed by other feelings and that he was lost to her. This failure of her first love pained her as often as she thought of it.

In this relationship and in the scene caused by it, I was to seek the causation of the first hysterical pain. A conflict, or a state of incompatibility arose through the contrast between the happiness which she had not at that time denied herself and the sad condition in which she found her father upon her arrival home. As a result of this conflict the erotic presentations were repressed from the associations and the affect connected with them was made use of in aggravating or reviving a simultaneously (or somewhat previously) existing physical pain. It was therefore the mechanism of a conversion for the purpose of defense as I have shown circumstantially in another place.[2]

To be sure, we have room here for all kinds of observations. I must assert that I was unsuccessful in demonstrating from her memory that the conversion took place in the moment of her returning home. I therefore investigated for similar experiences which might have occurred while she was nursing her father, and I evoked a number of scenes, among which was one during which she had to jump out of bed with bare feet in a cold room to respond to the repeated calls of her father. I was inclined to attribute to this moment a certain significance, for in addition to complaining of pain in her legs she also complained of tormenting sensations of coldness. Nevertheless, here too I could not with certainty lay hold of the scene which could be indicated as the scene of conversion. This led me to admit that there was here some gap, when I recalled the fact that the hysterical pains in the legs were really not present at the time she nursed her father. From her memory she recalled only a single attack of pain lasting a few days to which at that time she paid no attention. I then directed my attention to the first appearance of the pains. In this respect I was successful in awakening a perfect memory. They came on just at the time of a relative's visit whom she could not receive because she was ill in bed, and who had the misfortune to find her ill in bed on another occasion two years later. But the search for the psychic motive of these first pains failed as often as repeated. I believed that I could assume that these first pains were due to a slight rheumatic attack and really had no psychic basis, and I also discovered that this ganic

[2] Die Abwehr-Neuropsychosen, Neurologisches Centralblatt, 1 June, 1894.

trouble was the model for the later hysterical imitation, at all events that it occurred before the scene of being accompanied home. That these mild organic pains could continue for some time without her paying much attention to them is quite possible when we consider the nature of the disease. The obscurity resulting from this, namely, that the analysis pointed to a conversion of psychic excitement into bodily pain at a time when such pain was certainly not perceived and not recalled—this problem I hope to be able to solve in later considerations and by other examples.[8]

With the discovery of the motive for the first conversion we began a second more fruitful period of the treatment. In the first place very soon afterward the patient surprised me with the statement that she now knew why the pains always radiated from that definite location on the right thigh and were most painful there. This is really the place upon which her father's leg rested every morning while she changed the bandages of his badly swollen leg. That occurred hundreds of times, and strange to say she did not think of this connection until today. She thus gave me the desired explanation of the origin of an atypical hysterogenic zone. Furthermore during our analysis her painful legs always commenced to "join in the discussion." I mean the following remarkable state of affairs: The patient was as a rule free from pain when we began our work, but as soon as I evoked some recollection by question or by pressure of the head she at first reported some pain usually of a very vivid nature, and then winced and placed her hand on the painful area. This awakened pain remained constant as long as the patient was controlled by the recollection, reaching its height when she was about to utter the essential and critical part of her communication, and disappearing with the last words of the statement. I gradually learned to use this awakened pain as a compass. Whenever she was moody or claimed to have pains I knew that she had not told me everything, and urged a continuation of the confession until the pain was "spoken away." Then only did I awaken a new recollection.

During this period of ab-reaction, the patient's condition

[8] I can neither exclude nor prove that this pain, especially of the thighs, was of a neurasthenic nature.

showed such a striking improvement both somatically and psychically that I used to remark half jokingly that during each treatment I carried away a certain number of pain motives, and that when I had cleaned them all out she would be well. She soon reached a stage during which she had no pain much of the time; she consented to walk a great deal and to give up her hitherto condition of isolation. During the analysis I followed up now the spontaneous fluctuations of her condition and now some fragments of her sorrowful tale which in my opinion I had not sufficiently exhausted. In this work I made some interesting discoveries the principles of which I could later verify in other patients.

In the first place it was found that the spontaneous fluctuations never occurred unless provoked associatively by the events of the day. On one occasion she heard of an illness in the circle of her acquaintances which recalled to her a detail in the illness of her father. On another occasion the child of her deceased sister visited her and its resemblance to its mother recalled many painful incidents. On still another occasion it was a letter from her absent sister showing distinctly the influence of the inconsiderate brother-in-law, and this awakened a pain causing the reproduction of a family scene heretofore not reported.

As she never reproduced the same pain motives twice we were justified in the expectation that the stock would in time become exhausted. I never prevented her from merging into a situation tending to evoke new memories which had not as yet come to the surface. Thus for example I sent her to the grave of her sister, or I urged her to go in society where she was apt to meet her youthful friend who happened to be in the city.

In this manner I obtained an insight into the mode of origin of a hysteria which could be designated as mono-symptomatic. I found, for example, that the right leg became painful during our hypnosis when we dealt with memories relating to the nursing of her father, to her young friend, and to other memories occurring during the first period of the pathogenic term; while the pain in the left leg came on as soon as I evoked the memory of her lost sister, of both brothers-in-law, in brief of any impression relating to the second half of the history. My attention having been called to that by this constant behavior I went further

in my investigations and gained the impression that perhaps detailization went still further and that every new psychic cause of painful feeling might have some connection with a differently located painful area in the legs. The original painful location on the right thigh referred to the nursing of her father, and as the result of new traumas the painful area then grew by apposition so that strictly speaking we had here not one single physical symptom connected with a multiform psychic memory complex but a multiplicity of similar symptoms which on superficial examination seemed to be fused into one. To be sure I have not followed out the demarcations of the individual psychic causes corresponding to the pain zones for I found that the patient's attention was turned away from these relations.

Notwithstanding this I directed further interest to the mode of construction of the whole symptom-complex of the abasia upon this painful zone, and with this view in mind I asked such questions as this: "What is the origin of the pains in walking and standing, or on lying?" She answered these questions partially uninfluenced, partially under the pressure of my hand. We thus obtained two results. In the first place she grouped all scenes connected with painful impressions according to their occurrence, sitting, standing, etc. Thus, for example, she stood at the door when her father was brought home with his cardiac attack and in her fright remained as though rooted to the spot. To this first quotation "fright while standing" she connected more recollections up to the overwhelming scene when she again stood as if pinned near the death bed of her sister. The whole chain of reminiscences should justify the connection of the pain with standing up, and could also serve as an association proof, only one had to bear in mind the fact that in all these occasions we must demonstrate another moment which had served to direct the attention—and as a further result the conversion—just on the standing, walking, sitting, etc. The explanation for this direction of attention could hardly be sought in other connections than in the fact that walking, standing, and lying are connected with capabilities and conditions of those members which here bore the painful zones; namely, the legs. We could then easily understand the connection between the astasia-abasia and the first scene of conversion in this history.

Among the scenes which in consequence of this review had made the walking painful one which referred to a walk she had taken in company, at the watering place, which apparently lasted too long, stood out most prominently. The deeper circumstances of this occurrence revealed themselves only hesitatingly and left many a riddle unsolved. She was in an especially good humor and gladly joined the circle of friendly persons; it was a lovely day, not too warm, her mother remained at home; her older sister had already departed, the younger one felt indisposed but did not wish to mar her pleasure. The husband of the second sister at first declared that he would remain at home with his wife, but finally went along for her (Elisabeth's) sake. This scene seemed to have a great deal to do with the first appearance of the pains, for she recalled that she returned home from the walk very fatigued and with severe pains, she could not however say definitely whether she had perceived the pains before this. I took for granted that if she had suffered any pain she would have hardly resolved to enter upon this long walk. On being questioned whence the pains originated on this walk she answered rather indefinitely saying that the contrast between her solitude, and the married happiness of her sick sister, of which she was contantly reminded by the behavior of her brother-in-law, was painful to her.

Another closely related scene played a part in the connection of the pain with sitting. It was a few days later, her sister and brother-in-law had already departed and she found herself in an excitable longing mood. She arose in the morning and ascended a small hill which they were wont to visit together and which afforded the only pretty view. There she sat down on a stone bench giving free play to her thoughts. Her thoughts again concerned her lonesomeness, the fate of her family, and she now frankly admitted that she entertained the eager wish to become as happy as her sister. After this morning's meditation she returned home with severe pains. In the evening of the same day she took the bath, after which the pains definitely appeared and continued persistently.

We could further ascertain with great certainty that the pains on walking and standing diminished in the beginning on lying down. Only after hearing of her sister's illness and on leaving

Gastein in the evening, spending a sleepless night in the sleeping car, and being tormented simultaneously by the worries concerning her sister and violent pains, it was only then that the pains appeared for the first time while she was lying down, and throughout that time lying down was even more painful than walking or standing.

Thus the painful sphere grew by apposition first because every new pathogenically affecting theme occupied a new region of the legs, second, every one of the impressionable scenes left a trace because it produced a lasting, always more cumulative, "occupation" of the different functions of the legs, thus connecting these functions with the sensations of pain. There was unmistakably, however, still a third mechanism which furthered the production of astasia-abasia. When the patient finished the recitation of a whole series of events with the plaint that she then perceived pain in "standing alone," and when in another series referring to the unfortunate attempt of bringing about new conditions in the family she was not tired of repeating that the painful in that was the feeling of her helplessness, the sensation that she "could make no headway," I had to admit that her reflections influenced the formation of the abasia, and had to assume that she directly sought a symbolic expression for her painfully accentuated thoughts and had found it in the aggravation of her pains. That somatic symptoms of hysteria could originate through such symbolization we have already asserted in our Preliminary Communication, and in the epicrisis to this history. I will give some examples of conclusive evidence. In Miss Elisabeth v. R. the psychic mechanism of the symbolization was not in the foreground, it had not produced the abasia, but everything pointed to the fact that the already existing abasia had in this way undergone a considerable reenforcement. Accordingly this abasia as I met it in the stage of development was not only to be compared to a psychically associative paralysis of function but also to a symbolic paralysis of function.

Before I continue with the history of my patient I will add something about her behavior during the second period of the treatment. Throughout this whole analysis I made use of the method of evoking pictures and ideas by pressing the head, a method therefore, which would be inapplicable without the full

cooperation and voluntary attention of the patient. At times it was really surprising how promptly and how infallibly the individual scenes belonging to one theme succeeded each other in chronological order. It was as if she read from a long picture book the pages of which passed in review before her eyes. At other times there seemed to be inhibitions, of what kind I could not at that time surmise. When I exerted some pressure she maintained that nothing came into her mind. I repeated the pressure and told her to wait, but still nothing would come. At first when such obstinacy manifested itself I determined to discontinue the work and to try again, as the day seemed unpropitious. Two observations, however, caused me to change my procedure. Firstly, because such failure of this method only occurred when I found Elisabeth cheerful and free from pain and never when she had a bad day; secondly, because she frequently made assertions of seeing nothing after the lapse of a long pause during which her tense and occupied mind betrayed to me some psychic process within. I therefore decided to assume that the method had never failed, that under the pressure of my hands Elisabeth had each time perceived some idea or had seen some picture but that she was not always ready to inform me of it and attempted to repress the thing evoked. I could thing of two motives for such concealment; either Elisabeth subjected the idea that came to her mind to a criticism to which she was not entitled, thinking it not sufficiently important and unfit as an answer to the question, or she feared to say it because that statement was too disagreeable to her. I therefore proceeded as if I were perfectly convinced of the reliability of my technique. Whenever she asserted that nothing came into her mind, I did not let that pass. I assured her that something must have come to her but that perhaps she was not attentive enough, that I was quite willing to repeat the pressure. I also told her not to entertain any doubts concerning the correctness of the idea presenting itself to her mind, that that was not any of her concern; that it was her duty to remain perfectly objective and to tell whatever came into her mind, be it suitable or not, and I ended by saying that I knew well that something did come which she concealed from me and that as long as she would continue to do so she would not get rid of her pains. After such urging I found that

there was really no pressure that remained unsuccessful. I then had to assume that I correctly recognized the state of affairs, and indeed I won through this analysis perfect confidence in my technique. It often happened that only after the third pressure did she make a statement then added "Why I could have told you that the first time"—"Indeed why did you not say it"—"I thought that it was not correct:" or "I thought that I could avoid it, but it recurred each time." During this difficult work I began to attach a profounder significance to the resistance which the patient showed in the reproduction of her recollections, and I carefully compared these occasions in which it was especially striking.

I now come to the description of the third period of our treatment. The patient felt better, she was psychically unburdened and more capable, but the pains were manifestly not removed, reappearing from time to time with the old severity. The imperfect cure went hand in hand with the imperfect analysis, as yet I did not know in what moment and through what mechanisms the pains originated. During the reproduction of the most manifold scenes of the second period and the observation of the patient's resistance towards the reproduction, I formed a definite suspicion which I did not then dare to use as a basis for my action. An accidental observation turned the issue. While working with the patient one day I heard the steps of a man in the adjacent room and a rather pleasant voice asking some questions. My patient immediately arose requesting me to discontinue the treatment for the day because she heard her brother-in-law who just arrived asking for her. Before this disturbance she was free from pains but thereafter she betrayed by her mien and gait the sudden appearance of violent pains. This strengthened my suspicion and I decided to elicit the decisive explanation.

I questioned her concerning the circumstances and causes of the first appearance of the pains. Her thoughts were directed to the summer resort in that watering place where she had been before taking the journey to Gastein. A number of scenes were reproduced which had already been treated less exhaustively. They recalled her frame of mind at that time, the exhaustion following the worriment about her mother's vision and the nursing of her mother during the time of the operation and her final

despair at being unable as a lonesome girl to enjoy life or to accomplish anything in life. Until then she felt strong enough to dispense with the help of a man, but now she was controlled by a feeling of her womanly weakness, a yearning for love in which, to put it in her own words, "her obdurate self began to soften." In such humor the happy marriage of her younger sister made the profoundest impression on her. She thought how affectionately he cared for her, how they understood each other with a mere glance, and how sure they seemed to be of each other. It was truly regrettable that the second pregnancy followed so quickly the first and her sister knew that this was the cause of her suffering but how willingly she endured it and all because he was the cause of it. The brother-in-law did not at first wish to participate in the walk which was so intimately connected with Elisabeth's pain; he preferred to remain home with his sick wife, but the latter urged him with a glance to go because she thought that would give Elisabeth pleasure. Elisabeth remained with him throughout the whole walk; they spoke about the most varied and intimate things; she found herself in a thorough accord with all he said, and she became overwhelmed with the desire to possess a man like him. This was followed by a scene a few days later, when, on the morning after their departure, she visited the point commanding the beautiful view which had been their favorite walk. There she seated herself upon a stone and again dreamed of her sister's happiness and of a man like her brother-in-law who could engage her affections. When she arose she had pains which again disappeared, and only in the afternoon after having taken the warm bath did they reappear, remaining ever since. I attempted to investigate the thoughts which occupied her mind while taking the bath, but all I could obtain was that the bath house recalled her absent sister because she had lived in the same house.

For some time the state of affairs was clear to me. Absorbed in painfully sweet recollections she was wholly unconscious of the drift of her thoughts and continued to reproduce her reminiscences, the time in Gastein, the worry connected with the expectations of the letter, finally the information of her sister's illness, the long wait until the evening when she could first leave Gastein, the journey with its tormenting uncertainties during a

sleepless night—all these moments were accompanied by a violent aggravation of the pain. I asked her if during the journey she thought of the sad possibility which she afterward found realized. She answered that she carefully avoided the thought but that in her opinion her mother expected the worst from the very beginning. This was followed by the reminiscences of her arrival in Vienna—the impressions which she received from the relatives at the station, the short journey from Vienna to the neighboring summer resort where her sister lived, the arrival in the evening, the hasty walk through the garden to the door of the little garden pavilion—a silence in the house, the oppressive darkness, the fact of not having been received by the brother-in-law. She then recalled standing before the bed seeing the deceased, and in the moment of the awful certainty that the beloved sister had died without having taken leave of them and without having her last days eased through their nursing—in that very moment another thought flashed through Elisabeth's brain which now peremptorily repeated itself. The thought which flashed like dazzling lightning through the darkness was, "Now he is free again, and I can become his wife."

Of course, now everything was clear. The analyzer's effort was richly repaid. The ideas of the "defense" (abwehr) against an unbearable presentation, the origin of hysterical symptoms through conversion of psychic into physical excitement, the formation of a separate psychic group by an arbitrary act, leading to the defense—all these were in that moment palpably presented before my eyes. Thus and thus alone did things happen here. This girl entertained an affectionate regard for her brother-in-law against the acceptance of which into her consciousness her whole moral being struggled. She succeeded in sparing herself the painful consciousness that she was in love with her sister's husband by creating for herself instead bodily pains, and at the moment when this certainty wished to thrust itself into her consciousness (while she walked with him, during that morning reverie, in the bath, and before her sister's bed) her pains originated by means of a successful conversion into the somatic. When she came under my care there was already a complete isolation from her consciousness of the presentation group referring to this love, else, I believe that she would never

have agreed to such a treatment. The resistance which she repeatedly brought forth during the reproduction of traumatically produced scenes really corresponded to the energy with which the unbearable presentation had been crowded out from the association.

For the therapeutist there now came a sorry time. The effect of the resumption of that repressed presentation was a crushing one for the poor child. When I summed up the whole situation with these prosaic words: "you were really for a long time in love with your brother-in-law," she complained of the most horrible pains at that moment; she made another despairing effort to reject the explanation, saying that it was not true, that I suggested it to her, it could not be, she was incapable of such baseness, and that she would never forgive herself for it. It was quite easy to prove to her that her own information allowed no other interpretation, but it took a long time before the two reasons that I offered for consolation, namely, that one is not responsible for one's feelings and that her behavior, her sickness under those circumstances was sufficient proof of her moral nature—I say it took a long time before these consolations made an impression on her. I was now forced to pursue more than one course in order to calm the patient. In the first place I wished to give her the opportunity to rid herself by ab-reaction of the material long since accumulated. We investigated the first impressions of the relations with her brother-in-law, the beginning of those unconsciously kept affectionate regards. We found here all those little indications and forebodings which on a retrospective view showed a fully developed passion. On his first visit to the house he mistook her for his destined bride and greeted her before he greeted her older and homely sister. One evening they entertained each other so vivaciously and seemed to understand each other so well that the bride interrupted them with this half serious remark: "You two, indeed, would have suited each other very nicely." On another occasion while in a gathering who were ignorant of the engagement the conversation drifted to the young man, and a young lady indiscreetly remarked about a blemish in his shape, a juvenile joint affliction. The bride herself remained calm while Elisabeth flew into a passion, and with an ardor which even she herself could not after-

ward understand she defended the straight form of her future brother-in-law. While we worked our way through these reminiscences it became clear to Elisabeth that her affection for her brother-in-law had slumbered in her for a long time, perhaps since the beginning of their relations, and had concealed itself so long under the mask of a mere kinsmanlike affection as only her very delicate family feeling would allow.

This ab-reaction benefited her much, but I was able to give her still more relief by taking a friendly interest in her present state of affairs. With this object in view I sought an interview with Mrs. v. R. whom I found to be an intelligent and refined lady whose courage to face life, however, was somewhat lessened through the last misfortune. From her I learned that the accusation of rude extortion which the older brother-in-law had brought against the widower, and which was so painful to Elisabeth, had to be retracted on closer investigation. The character of the young man remained untarnished; it was merely a misunderstanding, an easily conceived difference of opinion concerning the valuation of money that could arise between the merchant, to whom money is only a working tool, and the official—that is all there was to this seemingly so painful incident. I begged the mother to give Elisabeth all explanations that she might hereafter need, and to offer her in the future that opportunity for unburdening her mind to which I had accustomed her.

Naturally I was also anxious to know what chance there was for the fulfillment of the girl's present conscious wish. Here things were less favorable! The mother stated that for some time she had had an inkling of Elisabeth's affections for her brother-in-law; of course she did not know that it existed during the lifetime of her sister. Whoever saw them both in friendly intercourse—of late, to be sure, only seldom—could entertain no doubt of the girl's anxiety to please him. However, neither she, her mother, nor the advisers of the family showed any particular inclination to bring about a matrimonial union between the two. The health of the young man had not been very good and had received a setback through the death of his beloved wife, and it was not at all certain that he had sufficiently recovered from the shock to enter into a new matrimony. It was quite probable that this was the reason for his reserve, perhaps also because he was

not sure of his position, and wished to avoid all obvious gossip. With such a reserve on both sides the solution for which Elisabeth was yearning was likely to fail.

I informed the girl of everything that I had heard from her mother and had the satisfaction of seeing her benefited by the explanation concerning the money affair. On the other hand, I expected her to bear calmly the uncertainties of her future which could not be set aside. The advancing summer compelled us to bring the treatment to an end. She now felt better, and since we had discussed the causes to which the pain could be traced she no longer complained of pain. We both felt that the work was done, although I thought that the ab-reaction of the suppressed love was really not as complete as it should have been. I regarded her as cured and urged her to continue independently the solution after the way had been cleared, to which she agreed. She left with her mother for a summer resort where they were to join the older sister and her family.

I still have something more to report about the further course of Miss Elisabeth v. R.'s disease. A few weeks after our parting I received a despairing letter from her mother informing me that at the first attempt to draw Elisabeth into a conversation about her love affairs she became very excited and refused to talk, and since then had suffered from violent pains. She was very indignant at my having betrayed her confidence and was perfectly inaccessible, so that the treatment seemed a complete failure. She wished to know what was to be done, for of me she would hear nothing. I made no reply. It was to be expected that after she was relieved from my discipline she would make another attempt to reject her mother's interference and return to her inaccessibility. I was, however, quite certain that everything would adjust itself and that my efforts had not been in vain. Two months later they returned to Vienna and the colleague to whom I was grateful for the case informed me that Elisabeth was perfectly well, and that her behavior was normal although occasionally she had slight pains. Since then she has repeatedly sent me similar messages, each time promising to visit me, which she has never done. This is quite characteristic of the personal relationship formed during such treatment. My colleague then

assured me that she could be considered cured. The relation of the brother-in-law to the family underwent no change.

In the spring of 1894 I was informed that she would be present at a private ball to which I could gain access. I did not let the opportunity escape me and saw my former patient gliding along in a rapid dance. Since then, following her own inclination, she has married a stranger.

Epicrisis.

I was not always a psychotherapist but like other neuropathologists I was educated to the use of focal diagnosis and electrical prognosis, so that even I myself am struck by the fact that the histories of the diseases which I write read like novels and, as it were, dispense with the serious features of the scientific character. Yet I must console myself with the fact that the nature of the subject is apparently more responsible for this issue than my own predilection. Focal diagnosis and electrical reactions are really not important in the study of hysteria, whereas a detailed discussion of the psychic processes, as one is wont to receive it from the poet, and the application of a few psychological formulæ, allows one to gain an insight into the course of events of hysteria. Such histories should be considered like psychiatrical ones, but they have the advantage over the latter in the fact that they give the intimate connection between the history of the disease and the morbid symptoms, a thing for which we still look in vain in the biographies of other psychoses.

With the description of the treatment I endeavored to interweave the explanations which I gave about the case of Miss Elisabeth v. R. and it will perhaps be superfluous to summarize here the essential features. I have discussed the character of the patient and the features which repeat themselves in so many hysterics, and which we really can not consider as degenerative. I mentioned the talent, the ambition, the moral sensitiveness, the immense yearning for love which found its gratification in the family, the independence of her nature reaching beyond the womanly ideal which manifested itself largely by obstinacy, readiness for fight, and inaccessibility. According to the information of my colleague no hereditary taints could be shown on either side of the family. Her mother, to be sure, suffered for years

from some indefinite neurotic depression, but her brothers and sisters, her father and his family belonged to the even-tempered and not to the nervous. There was no serious case of neuropsychosis in the nearest relatives.

This nature was acted upon by painful emotions, the foremost of which was the debilitating influence of a long attendance upon her beloved sick father.

That nursing of the sick plays such a significant rôle in the histories of hysterias has its good reasons. A number of effective moments which are found here are quite obvious, namely, the disturbance of the physical health through interrupted sleep, neglect of nourishment, and the reaction of a constantly gnawing worriment on the vegetative functions; but the most important factor, however, is, in my estimation, to be found elsewhere. He whose mind is occupied with the hundred different tasks of nursing which succeed each other continuously for weeks and months, becomes accustomed, on the one hand, to suppress all signs of his own emotions, and on the other, his attention is soon turned away from his own impressions because he has neither the time nor strength to do them justice. Thus the nurse accumulates for himself an overabundance of affective impressions which he barely perceived clearly enough; at any rate they were not weakened by ab-reaction, that is, he creates for himself the material for a retention hysteria. If the patient recovers these impressions naturally become reduced in value, but if he dies and the period of mourning comes during which only that which refers to the deceased seems of value, the impressions waiting for discharge appear in turn, and after a brief pause of exhaustion the hysteria, the germ of which originated during the nursing, bursts forth.

The same subsequent discharge of traumas accumulated during nursing is occasionally encountered where the general impression of the disease does not ensue, and yet the mechanism of hysteria can be noticed. Thus, I know a highly gifted but slightly nervous lady whose whole personality suggests the hysteric though she never became a burden to the doctor and was never obliged to interrupt the exercise of her duties. This lady had nursed three or four of her beloved ones until their death, causing her each time complete physical exhaustion, yet these sad

duties never made her ill. However, shortly after the death of the patient she began the work of reproduction, bringing again to her view the scenes of the disease and death. Each day—one might say at her leisure—she went over again every impression, crying and consoling herself. Such adjustment she passed through daily in conjunction with her usual duties, without, however, confusing the two activities. Everything passed before her chronologically. Whether the memory work of one day precisely corresponded to a day of the past I am unable to say. I presume that it depended on the leisure which was allowed to her by the current affairs of the household.

Aside from this "subsequent tear" which attached itself to these deaths at short intervals, this lady periodically observed annual anniversaries representing the time of the various catastrophies, and here her vivid visual reproduction and her affective manifestations followed faithfully the date. Thus, for example, I found her in tears, and on sympathetic inquiry as to what occurred that day, she half irritably remarked, "Nothing on that day except that Professor N. was again here and gave us to understand that things were hopeless—at that time I had no time to cry." She referred to the last illness of her husband who died three years before. It would have been very interesting to know whether she always repeated the same scenes on these recurring anniversaries, or whether as I suppose in the interest of my theory other details presented themselves each time for ab-reaction. I was, however, unable to find anything definite about that; the wise and courageous woman was ashamed of the intensity with which those reminiscences acted upon her.[4]

[4] To my surprise I once discovered that such subsequent ab-reaction —through other impressions than nursing—may form the content of an otherwise enigmatic neurosis. It was the case of a pretty girl of nineteen, Miss Matilda H., whom I first saw with an incomplete paralysis of the legs and months afterward I was again called because her character had changed. She was depressed and tired of living, entertaining lack of consideration for her mother, and was irritable and inapproachable. The whole picture of the patient did not seem to me to be that of an ordinary melancholia. She could easily be put into a somnambulic state, and I made use of this peculiarity to impart to her each time commands and suggestions to which she listened in her profound sleep and responded with profuse tears, but which, however, caused but little change in her condition. One day while hypnotized she became talkative and informed

I again repeat that this woman was not sick, that subsequent ab-reaction, despite all resemblance, is still not a hysterical process; one may ask why, after one nursing there results a hysteria and after another none. It cannot lie in personal predisposition, for the lady that I have in mind showed it very remarkably.

I now return to Miss Elisabeth v. R. While nursing her father there occurred for the first time an hysterical symptom in the form of a pain in a definite location on the right thigh. The mechanism of this symptom is fully explained on an analytical basis. It occurred in a moment during which the ideas of her duties towards her sick father came into conflict with the content of her erotic yearning which she then entertained. Under vivid self reproach she decided in favor of the former and created for herself the hysterical pain. According to the conception explained by the theory of conversion in hysteria, the process could be described as follows: She repressed the erotic idea from her consciousness and changed the sum of the affect into somatic sensations of pain. Whether this first conflict occurred only once, or repeated itself is not clear. The latter is more probable. Quite a similar conflict—of a higher moral significance, and even

me that the reason for her depression was the breaking of her betrothal many months before. She stated that on closer acquaintance with her fiance the things displeasing to her and her mother became more and more evident. On the other hand, the material advantages of the engagement were too tangible to make the decision of a rupture easy, thus, both of them hesitated for a long time. She then merged into a condition of indecision in which she allowed everything to pass apathetically and finally her mother pronounced for her the decisive "no." Shortly after, she awoke as from a dream and began to occupy herself fervently with the thoughts about the broken betrothal, she began to weigh the pros and cons, a process which she continued for some time. At present she continues to live in that time of doubt, and entertains daily the moods and the thoughts which would have been appropriate for that day. The consideration the circumstances that existed on that decisive day. Next to this thought activity she found her present life a mere phantom just irritability against her mother could only be explained if we took into like a dream. I did not again succeed in getting the girl to talk—I continued my exhortations during deep somnambulism. I saw her each time burst into tears without however receiving any answer from her. But one day, it was near the anniversary of the engagement, the whole state of depression disappeared. This was attributed to my great hypnotic cure.

better demonstrated by the analysis—repeated itself after years and led to the aggravation of the same pain and to its dissemination beyond its original limits. Again, it was an erotic idea which came into conflict with all her moral conceptions, for her affection for her brother-in-law, both during the life and after the death of her sister, and the thought that she should yearn just for this man, was to her very disagreeable. This analysis gives detailed information about this conflict which represents the pivotal point in the history of her malady. The patient's affection for her brother-in-law might have begun to germinate long ago, but in favor of its development was the physical exhaustion through the recent nursing, and her moral exhaustion through years of disillusionment which then began to break down her reserve and she confessed to herself the need of the love of a man. During a friendly intercourse continuing for weeks (in the summer resort) this erotic inclination reached its full development simultaneously with the pain. The analysis shows a special psychic condition of the patient at that time, which in connection with her inclination and the pain, seems to afford an understanding of the process in the sense of the conversion theory.

I place reliance on the opinion that the patient's affection for her brother-in-law, intensive as it was, was not clearly known to her except on certain rare occasions and then only momentarily. If that were not so she would have become conscious of the inconsistency between this fondness and her moral ideas and would have had to endure the same mental agony which I saw her suffer after the analysis. Her reminiscences gave us no information concerning such suffering. These she spared herself and as a result the love itself did not become clear to her. At that time, as well as during the analysis, her love for her brother-in-law existed in the form of a foreign body in her consciousness without entering into any relationship with her other ideation. In reference to this love there existed the peculiar condition of knowing and simultaneously not knowing, it was the condition of the split-off psychic group. When we assert that this love was not "clearly known" to her we mean exactly what we say. We do not mean a lower quality or a lesser degree of consciousness, but a separation of the free associative thinking process from the rest of ideation.

How does it come about that such an intensively accentuated presentation group should be kept so isolated? As a rule the rôle played by an idea in the association really increases with the sum of its affect.

This question can be answered if we bear in mind two facts which we can make use of as a safeguard: (1) That the hysterical pains originated simultaneously with the formation of these separate psychic groups, (2) that the patient exerted great resistance against the attempt to bring about the association between the separate psychic groups and the rest of the content of consciousness, and when the union was finally effected she perceived excessive psychic pain. Our conception of hysteria brings together these two moments with the fact of the splitting of consciousness, for (2) contains the indication for the motive for the splitting of consciousness while (1) shows the mechanism of the same. The motive was that of defense, it was the striving of the whole ego to agree with this presentation group and the mechanism was that of conversion, that is, instead of psychic pains which she spared herself there appeared physical pains. Thus a transformation occurred through which pain the patient had escaped an unbearable psychic state, though it was at the cost of a psychic anomaly in the form of a splitting of consciousness and a physical suffering, pains, upon which an astasia-abasia was constructed.

To be sure I can give no instruction as to how one can bring about such a conversion. It is not apparently done as one intertionally does an arbitrary action, it is a process which is executed in the individual under the impulse of the motive of defense if an adaptation for it exists in his organization or is brought about by temporary modification.

One has the right to attack the theory more closely by asking what it is that is transformed into physical pains. The cautious reply will be something out of which psychic pains could have and should have been formed. If we wish to venture further and attempt a kind of algebraic formulation of the presentation mechanism we may attribute to the presentation complex of this unconsciously remaining love a certain amount of affect and designate the latter quantity as the thing converted. Direct deduction of this conception would be the fact that the "unconscious love" has through such conversion forfeited so much of its intensity that

it was reduced to a weak idea. Its existence as a separate psychic group would only be made possible through such weakening. Yet this present case it not suitable to afford us any clearness in this delicate matter. It probably corresponds to an imperfect conversion only. From other cases it seems quite probable that perfect conversions also occur and that in these the unbearable idea actually becomes repressed as only an idea of very little intensity could be repressed. After an associative union has been consummated the patients assure us that since the origin of the hysterical symptoms their unbearable thoughts never occupied their minds.

I have stated above that on certain occasions, though only transitorily, the patient consciously recognized the love for her brother-in-law. Such a moment occurred when for example, at the death bed of her sister the thought flashed through her mind, "Now he is free and I can become his wife." I must discuss the significance of these moments for the conception of the whole neurosis. However, I think that the assumption of a defense hysteria (abwehr hysterie) includes the requisite that at least one such moment has already occurred. For consciousness does not know in advance when such an unbearable idea will present itself. The unbearable idea which with its appendix is later excluded for the formation of a separate psychic group must have been originally in the mind, otherwise no conflict would have resulted leading to its exclusion.[5] Just such moments should be designated as "traumatic." It is in them that the conversion takes place which results in the splitting of consciousness and the hysterical symptoms. Everything tends to show that in Miss Elisabeth v. R. there were a number of such moments (the scenes of the walking, morning meditation, bath, and at the bed of her sister) and perhaps new moments of this kind occurred during the treatment. The multiplicity of such traumatic moments is made possible by the fact that an experience similar to the one which at first initiated the unbearable idea, introduces new emotions to the separated psychic groups and thus transitorily abolishes the success of the conversion. The ego is forced to occupy itself with this suddenly enforced and lighted-up idea, and then

[5] It is different in a hypnoid hysteria. Here the content of the separate psychic groups may never have been in the ego consciousness.

to restore the former state by means of new conversions. Miss Elisabeth, who was in constant relation with her brother-in-law, must have been particularly exposed to the appearance of new traumas.

I must now occupy myself with the point which I have designated as a difficulty for the understanding of the aforementioned history. On the analytical basis I assume that the first conversion took place in the patient while she nursed her father, at the time when her duties as nurse came into conflict with her erotic yearnings, and that this process was the prototype for the later ones which led to the outbreak of the disease in the Alpine watering place. But then we have it from the patient's statement that at the time of nursing and the period following which I designated as the "first period" she had not suffered at all from the pains and weakness. To be sure, during the illness of her father she was once bedridden for a few days with pains in her legs, but it is doubtful whether this attack already belonged to the hysteria. A causal relation between these first pains and any psychic impressions could not be demonstrated by analysis; it is possible, even probable, that at that time we dealt with a common rheumatic muscular pain. Even if we should assume that this first attack of pain was the result of a hysterical conversion in consequence of the rejection of the erotic thoughts then existing, the fact nevertheless remains that the pains disappeared after a few days, so that the patient actually behaved differently than she did during the analysis. During the reproduction of the so called first period all her statements concerning the illness and death of her father, the impressions relating to her first brother-in-law, etc., all these were accompanied by manifestations of pain, while at the time she really experienced these impressions she perceived no pains. Is this not a contradiction tending to considerably diminish the confidence in the explanatory value of such an analysis?

I believe that I can explain the contradiction by assuming that the pains—the product of the conversion—did not originate while the patient experienced the impressions during the first period, but subsequently, that is, in the second period when the patient reproduced these impressions in her mind. The conversion did not follow the fresh impressions but the memories of them. I even believe that such a process is not at all unusual

in hysteria and regularly participates in creating hysterical symptoms. Nevertheless, as such an assertion does not seem plausible I shall attempt to make it more credible by citing other experiences.

It once happened to me during a similar analysis that a new hysterical symptom was formed during the treatment so that I could attempt its removal on the day after its origin.

I will describe the essential features of the history of this patient. They are simple but not without interest.

Miss Rosalia H., twenty-three years old, who for a number of years made great effort to educate herself as a singer, complained that her beautiful voice did not obey her in certain notes. There appeared choking and tightening sensations in the throat so that the tones sounded strained, and her teacher could therefore not allow her to appear in public. Although this imperfection affected only her middle notes it could not be explained to be due to a defect of her vocal organs, for at times this disturbance was absent and her teacher was very pleased with her, but at other times the slightest excitement, seemingly without any provocation, evoked the choking sensation, and prevented free expansion of the voice. It was not difficult to recognize in this annoying sensation an hysterical conversion. Whether there really appeared a contracture of certain muscles of the vocal chords I have not verified.[6] In the hypnotic analysis which I undertook with this girl I found out the following concerning her vicissitudes and her ailments occasioned through them. She became an orphan at an early age and was brought up at the house of an aunt who had many children of her own, and she thus shared

[6] I had under my observation another case in which a contracture of the masseters made it impossible for the artist to sing. The young lady in question through painful experiences in the family was forced to go on the stage. While in Rome rehearsing, in great excitement she suddenly perceived the sensation of being unable to close her opened mouth and sank fainting to the floor. The physician who was called closed her jaws forcibly, but the patient since that time was unable to open her jaws more than a finger's breadth and had to give up her newly chosen profession. When she came under my care many years later, the motives for that excitement were apparently over for some time, for massage in a light hypnosis sufficed to open her mouth widely. The lady has since sung in public.

the life of a most unfortunate family. The husband of this aunt, seemingly a pathological personality, abused his wife and children in the most brutal manner and especially pained her by his sexual preference for the servant girl in the house. This became even more obnoxious as the children grew older. When the aunt died Rosalia became the protectress of the orphaned children who were harassed by their father. She took her duties seriously, fought through all conflicts and had to exert her greatest efforts to suppress the manifestations of her contempt for her uncle. It was then that the choking sensation in her throat originated. Whenever she was compelled to swallow an affront, whenever she had to remain silent on hearing a provoking accusation she perceived a scratching in her throat, the tightening and failure of her voice; in brief she had all the localized sensations in her larynx and pharynx which now disturbed her in singing. It was conceivable that she sought the possibility of making herself independent in order to escape the excitement and painful impressions which were daily occurrences in her uncle's house. An efficient music teacher took an unselfish interest in her, assuring her that her voice entitled her to choose the profession of singing. She began secretly to take lessons of him and because she often went for her lessons with the choking sensation in her throat following some violent scene in the house, a connection was formed between the singing and the hysterical paresthesia for which a way was prepared by the sensitiveness of the organ during singing. The apparatus of which she should have had free control was filled with the remnants of innervation after those numerous scenes of repressed excitement. Since then she has left the house of her uncle, having moved to another city so as to be away from the family, but her ailments were not benefited by it. No other hysterical symptoms were discovered in this pretty and unusually bright girl.

I endeavored to cure this "retention-hysteria" by a reproduction of all the exciting impressions and by subsequent ab-reaction. I afforded her the opportunity of railing against her uncle in long speeches and of telling him the bare truth to his face, etc. The treatment benefited her, but unfortunately she lived here under quite unfavorable conditions. She had no luck with her relatives. She was the guest of another uncle who treated her

with friendliness, but just for that reason she incurred the displeasure of her aunt. The latter believed that her husband evinced too marked an interest in his niece and made it a point of opposing the girl's stay in Vienna. She herself in her youth was obliged to relinquish a desire of becoming an artist and was now jealous of her neice because she had the opportunity to develop her talent not considering that it was not mere desire but a wish to become independent which led her neice to take this step. Rosalia felt so uncomfortable in the house that she for instance, did not dare to sing or play the piano when her aunt was within hearing distance, and carefully avoided either singing or playing anything for her aged uncle—brother of her mother—whenever her aunt was home. While I was endeavoring to efface the traces of the old excitements, new ones originated through these relations with her host and finally interfered with the success of my treatment and prematurely interrupted the cure.

One day the patient came to me with a new symptom hardly twenty-four hours old. She complained of a disagreeable prickling sensation in the fingertips which had manifested itself every few hours since the day before and forced her to make very peculiar jerky movements with the fingers. I could not see the attack, otherwise I would have guessed its meaning on seeing the finger movements but I immediately endeavored to trace through hypnotic analysis the causation of this symptom (it was really a minor hysterical attack). As the whole thing only existed for a short time I hoped to be able to explain it and quickly remove it. To my surprise without any hesitation she reproduced in chronological order a whole row of scenes beginning in her early childhood. All these had perhaps the same characteristics in the fact that she had suffered an injustice without defense, something which could make her fingers jerk, for example, scenes like the one of being forced to hold out her hand in school while her teacher struck it with a ruler. But they were all banal causes the right of which to enter into the etiology of an hysterical symptom I have already opposed. It was different, however, with one scene of her early girlhood which was connected with the others. The bad uncle who suffered from rheumatism asked him to massage his back. She did not dare refuse him. He was in bed while she was doing it and suddenly threw

off the covers, jumped up, attempting to get hold of her and throw her down. Naturally she stopped the massage and in a moment escaped and locked herself within her own room. She evidently did not like to recall this experience and could not say whether she had seen anything when the man suddenly exposed himself. The sensations of the fingers could be explained as due to the suppressed impulse to punish him, or it might simply have originated from the fact that she was at that time massaging him. Only after this scene did she begin to talk about the one experienced yesterday after which the sensitiveness and jerkiness of the fingers appeared as a recurring memory symbol. The uncle with whom she now lived begged her to play something for him. She sat at the piano and accompanied herself singing, believing that her aunt was out. Suddenly she appeared in the doorway, Rosalie jumped up, closed the piano, and flung away the sheet of music. We can guess what memories came to her mind, and the train of thought which she tried to ward off at that moment, for the exasperation brought on by the unjust accusation should have really urged her to leave the house, but on account of her illness she was forced to remain in Vienna and had no other shelter. The movement of the fingers which I saw during the reproduction of this scene resembled a continuous jerking, as if one literally and figuratively would reject something like throwing away a sheet of music or rejecting an unreasonable demand.

She was quite positive in her assurance that she did not perceive the symptom before, that it was not caused by the scenes previously related. Was there anything else to be assumed except that the scene experienced yesterday had in the first place awakened the recollection of a former similar content and that then the formation of a memory symbol for the whole group of recollections took place? The conversion was on the one hand furnished with newly experienced affects, on the other with recollected affects.

When we consider this state of affairs we must admit that in the origin of hysterical symptoms such a process is the rule rather than the exception. Whenever I seek for the determinants of such states I frequently find not a single but a group of similar traumatic motives. In some cases it could be ascertained that this particular symptom had already existed for a short time after

the first trauma and then subsided, but reappeared after the next trauma and become fixed. Yet no real distinction can be made between the temporary appearance and the latency after the first motives. In a large majority of cases it was also found that the first traumas had left no symptoms, while a later trauma of the same kind produced a symptom for the origin of which the co-operation of the former motives could not be dispensed with and for the solution of which it really required a consideration of all the motives. Translating this into the language of the conversion theory we will say that this undeniable fact of the summation of the traumas and the erstwhile latency of the symptoms simply means that the conversion can be brought about from a fresh as well as from a remembered affect, and this assumption fully explains the contradiction which seems to exist in the history and analysis of Miss Elisabeth v. R.

There is no question that normal persons carry in their consciousness in considerable numbers the continuation of ideas with unadjusted affects. The theory which I just asserted merely approximates the behavior of hysteria to the normal. It is apparently reduced to a quantitative moment; it is simply a question of how many such affective strains an organization can endure. Even a hysterical person will be able to retain a certain amount in an unadjusted state, but if through a summation of similar motives it increases beyond the individual's endurance, the impetus for conversion is formed. It is therefore no singular theory but almost a postulate to say that the formation of hysterical symptoms may also be brought about at the cost of recollected affects.

I have now occupied myself with the motive and mechanism of this case of hysteria, it still remains to discuss the determination of the hysterical symptoms. Why should just the pains in the legs be selected to represent the psychic pains? The circumstances of the case point to the fact that this somatic pain was not created by the neurosis but was merely utilized, aggravated, and retained by it. I will add that in most of the cases of hysterical algias into which I have been able to gain an insight the conditions were similar, that is, there was to begin with always a real organically founded pain. It is always the most common, the most widespread pains of humanity that seem to be most frequently called upon to play a part in hysteria. Among the most common

are the periosteal and neuralgic pains of the teeth, headaches which originate from so many different sources, and not in a lesser degree the so often mistaken rheumatic pains of the muscles. The first attack of pain which Miss Elisabeth v. R. had while she nursed her father, I consider to have been organically determined, for I received no information when I investigated for its psychic motive, and I admit that I am inclined to attribute differential diagnostic significance to my methods of evoking hidden memories if they are carefully applied. This original rheumatic pain[6] became in the patient the memory symbol for her painful psychic emotions, and as far as I can see, for more than one reason. First and principally because it existed in consciousness almost simultaneously with the other excitements, and second because it was or could be connected in many ways with the ideation of that time. At all events it was perhaps a remote consequence of the nursing, of her want of exercise, and the poor nutrition entailed by her duties as nurse. But this hardly became clear to the patient, and what is more important is the fact that she had to perceive it during significant moments of the nursing, as for example, when she jumped out of bed in the cold room to respond to her father's call. Even more decisive for the direction taken by the conversion must have been the other manner of associative connection, namely, the fact that for many days one of her painful legs came in contact with the swollen leg of her father during the changing of bandages. The location on the right leg distinguished by this contact remained henceforth the focus and starting point of the pains, an artificial hysterogenic zone the origin of which can be plainly seen in this case.

If any one should be surprised at the associative connection between physical pain and psychic affect, thinking it to be too manifold and artificial, I should answer that such surprise is just as unfair as to be surprised over the fact "that just the richest in the world possess most money." Where prolific connections do not exist there is naturally no formation of hysterical symptoms, and conversion does not find its way. I can also state that in reference to determinations the case of Miss Elisabeth v. R. belongs to the simpler ones. In the case of Mrs. Cäcilie M. particularly, I had to solve the most intricate knots of this kind.

[6] But perhaps spinal neurasthenic?

[7] See Studien über Hysterie, p. 57, footnote.

I have already discussed in the history of the case how the astasia-abasia of our patient was built up on those pains after the conversion had taken definite direction. But there, too, I have expressed the opinion that the patient has created or aggravated the disturbance of function through symbolization. For her dependence and helplessness to change anything in the circumstances she found a somatic expression in the astasia-abasia, and the expressions "to make no headway," "to have no support," etc., formed the bridge for this new act of conversion. I will endeaver to support this conception by other examples.

Conversion on the basis of coincidence in otherwise existing associative connections seems to exert the slightest claims on the hysterical predisposition; on the other hand conversion through symbolization seems to require a higher grade of hysterical modification, a fact also demonstrated in Miss Elisabeth in the later stages of her hysteria. The prettiest examples of symbolization I have observed in Mrs. Cäcilie M.,[8] whom I can call my most difficult and most instructive case. I have already mentioned that this history does not unfortunately lend itself to detailed reproduction.

Among other things Mrs. Cäcilie also suffered from a most violent facial neuralgia which appeared suddenly two or three times during the year and persisted for from five to ten days, resisting every remedy, and ceased as if cut off. It limited itself to the second and third branches of the trigeminus, and as there was undoubtedly an excess of urates in the urine, and as a not very "clear acute rheumatism" played a certain part in the patient's history it was reasonable to assume that we dealt with a gouty neuralgia. This opinion was also shared by the consulting physicians who saw every attack. The neuralgia was treated with the methods in vogue, such as electric penciling, alkaline waters and purgatives, but it always remained uninfluenced until it was convenient to make room for another symptom. In former years—the neuralgia was fifteen years old—the teeth were accused of preserving it and were condemned to extraction, and one fine morning under narcosis the execution of seven of the culprits took place. That did not run so smoothly as the teeth were so firm that most of the roots were left behind. This cruel opera-

[8] l. c.

tion was followed by neither temporary nor permanent relief. At that time the neuralgia raged for months. Even while under my care whenever she had neuralgia the dentist was called and he always declared he found diseased roots. He commenced to get ready for such work but usually he was soon interrupted, for the neuralgia suddenly ceased and with it the desire for the dentist. During the intervals the teeth did not ache at all. One day just while another attack was raging I put the patient into a hypnotic condition and placed an energetic interdiction on the pains, and from that moment they ceased. I then began to doubt the genuineness of this neuralgia.

About a year after this hypnotic remedial success the condition of Mrs. Cäcilie M. took a new and surprising turn. There suddenly appeared other states than those that had been characteristic of the last years, but after some reflection the patient declared that all these conditions had existed in her before and were really scattered over the long period of her disease (thirty years). Indeed a surprising abundance of hysterical incidents were unrolled which the patient was able to localize correctly in the past and soon the frequently very entangled thought connections which determined the sequence of these incidents became recognizable. It was like a series of pictures with an explanatory text. Pitres, on describing his délire ecmnésique, must have had in mind a similar case. The way such a hysterical condition belonging to the past was reproduced was most remarkable. In the first place while the patient was in the best of condition there appeared a pathological mood of special coloring which was regularly mistaken by the patient and was referred to a banal occurrence of the last hours. This increasing obnubilation of consciousness was followed by hysterical symptoms, such as hallucinations, pains, convulsions, and long declamations, and finally an event of the past attached itself to this hallucinatory manifestion which could explain the initial mood and determine the occasional symptoms. With this last part of the attack lucidity returned, the ailments disappeared as if by magic and good health again existed—until the next attack which was half a day later. Usually I was called at the height of this condition. I produced hypnosis, evoked a reproduction of the traumatic events, and by artificial aid I curtailed the attack. Having gone through with the patient

many hundreds of such cycles, I obtained the most instructive explanations concerning the determinants of hysterical symptoms. The joint observation with Breuer of this remarkable case was also the chief motive for the publication of our "Preliminary Communication."

In this connection it finally came to the reproduction of the facial neuralgia which I myself had still treated as actual attacks. I was desirous of knowing whether we would find here a psychic causation. When I attempted to evoke the traumatic scene, the patient soon imagined herself in a period during which she felt marked psychic sensitiveness against her husband. She related a conversation with him and a remark that he made which aggravated her very much. She then suddenly grasped her cheek, crying aloud with pain, and said, "That was like a slap in the face"—with this both the attack and the pain came to an end. There is no doubt that here, too, we dealt with a symbolization. She had felt as if she really received a slap in the face. Now everybody will ask how the sensation of "a slap in the face" can lead to the manifestations of a trigeminal neuralgia, to its limiting itself to the second and third branch, and to its being aggravated on opening the mouth and mastication (not by talking!).

The following day the neuralgia reappeared, but this time it could be solved by the reproduction of another scene the content of which equally showed a supposed insult. This process continued for nine days; from the result it seemed that for years, aggravations, especially through words, produced new attacks of this facial neuralgia by way of symbolization.

But finally we also succeeded in reproducing the first attack of the neuralgia which occurred more than fifteen years before. Here there was no symbolization but a conversion through coincidence. It was a painful sight which recalled to her mind a reproach and this caused her to repress another series of thoughts. We have here, then, a case of conflict and defense, and the origin of the neuralgia in this moment could not be explained if we do not wish to assume that she then suffered from slight toothache or facial pains, a thing not improbable, as she was then in the first months of pregnancy.

The result of the explanation showed that this neuralgia became the mark of a definite psychic excitement through the usual road

of conversion but that afterward it could be awakened through associative reminiscences of thoughts and symbolic conversions. It was really the same procedure as encountered in Miss Elisabeth v. R.

I will now introduce another example which will illustrate the efficacy of symbolization under other determinants. On one occasion Mrs. Cäcilie M. was tormented by a violent pain in her right heel, experiencing stinging sensations which made walking impossible. The analysis conducted us to a time when the patient was in a foreign institution. For eight days she lay in her room, and for the first time the house physician was to take her to the dining room. The pain came on while the patient took the physician's arm on leaving the room. It disappeared during the reproduction of this scene while she remarked that at that time she feared lest she would not make the "proper impression" on this strange society[9] ("rechte Auftreten").

This seems a striking, almost comical example for the origin of hysterical symptoms through symbolization by means of an expression of speech. But a closer investigation of the circumstances of that moment will favor another conception. The patient at that time suffered from pain in her feet on account of which she remained in bed, and we can only assume that the fear which obsessed her on taking the first steps produced from the simultaneously existing pains the one symbolically appropriate symptom in the right heel so as to form it into a psychic algia and to particularly fit it for long duration.

Notwithstanding the fact that the mechanism of symbolization in these examples seems to be crowded to second rank, that which certainly corresponds to the rule, I have still other examples at my disposal which seem to demonstrate the origin of hysterical symptoms through symbolization only. One of the best is the following example which again refers to Mrs. Cäcilie M. At the age of fifteen she once lay in bed watched by her austere grandmother. The girl suddenly cried out complaining of having perceived a pain in the forehead between the eyes which thereafter continued for weeks. On analyzing this pain, which was reproduced after almost thirty years, she stated that her grandmother gazed at her so "piercingly" that it seemed as if her look



[9] The literal translation of Auftreten is to press down by treading.

penetrated deeply into her brain. She was really afraid of being looked upon suspiciously by this old lady. On reproducing this thought she burst into loud laughter and the pain ceased. Here I find nothing other than the mechanism of symbolization which in a way stands midway between the mechanism of auto-suggestion and that of conversion.

The study of Mrs. Cäcilie M. gave me the opportunity to gather a collection of such symbolizations. A whole series of physical sensations which were otherwise looked upon as organically determined were of a psychic origin, or at least furnished with a psychic interpretation. A certain number of her experiences were accompanied by a piercing sensation in the region of the heart ("I felt a stitch in my heart"). The piercing headache of hysteria was undoubtedly, in her case, to be interpreted as thought pains ("something sticks in my head"), and it disappeared each time when the problem in question was solved. The sensation of the hysterical aura in the throat, when it manifested itself during an aggravation, ran parallel with the thought, "I have to swallow that." There was a whole series of parallel running sensations and ideas in which it was now the sensation evoking the idea as an interpretation and now the idea which produced the sensation by symbolization, and not seldom it remained obscure which was the primary element of the two.

In no other patient was I able to find such a prolific application of symbolization. To be sure, Mrs. Cäcilie M. was a person of quite unusual and of a special artistic temperament whose highly developed sense for form manifested itself in very beautiful poems. I maintain, however that if a hysteria creates through symbolization a somatic sensation for the emotionally accentuated presentation, it is due less to individual and arbitrary things than one supposes. When during an offending harangue she takes literally such phrases as "stitch in the heart" or "slap in the face," and perceives them as real occurrences she practices no facetious misuse but only revives the sensations to which this phrase thanks its existence. For how does it happen that in speaking of an aggrieved person we use such expressions as "he experienced a 'stitch in his heart,'" if the mortification was not actually accompanied by a precordial sensation that could be so interpreted and recognized? Is it not probable that the phrase

"to swallow something" applied to an unreturned insult really originates from the sensation of innervation appearing in the pharynx when one forces back his speech, thus preventing a reaction to the insult? All these sensations and innervations belong to the "expression of the emotions," which as Darwin taught us, originally consisted of sensible and expedient actions; at present most of them may be so weakened that their expression in speech seems to us like a figurative transformation, but very probably all this was once meant literally, and hysteria is justified in reconstructing the original literal sense for its stronger innervation. Indeed, perhaps it is improper to say that it creates such sensations through symbolization, perhaps it has not taken the usage of speech as a model, but both originated from a common source.[10]

[10] In conditions of profounder psychic changes we apparently find a symbolic stamp (mark) of the more artificial usage of language in the form of emblematic pictures and sensations. There was a time in Mrs. Cäcilie M. during which every thought was changed into an hallucination, and which solution frequently afforded great humor. She at that time complained to me of being troubled by the hallucination that both her physicians, Breuer and I, were hanged in the garden on two nearby trees. The hallucination disappeared after the analysis revealed the following origin: The evening before Breuer refused her request for a certain drug. She then placed her hopes on me but found me just as inflexible. She was angry at both of us, and in her affect she thought, "They are worthy of each other, the one is a pendant of the other!"

CHAPTER IV.

THE PSYCHOTHERAPY OF HYSTERIA.

In our "Preliminary Communication" we have stated that while investigating the etiology of hysterical symptoms we have also discovered a therapeutic method which we consider of practical significance. "We found, at first to our very greatest surprise, that the individual hysterical symptoms immediately disappeared without returning if we succeeded in thoroughly awakening the memories of the causal process with its accompanying effect, and if the patient circumstantially discussed the process giving free play to the affect" (p. 4).

We furthermore attempted to explain how our psychotherapeutic method acts. "It does away with the effects of the original not ab-reacted to ideas by affording an outlet to the suppressed affect through speech. It brings it into associative correction by drawing it into normal consciousness (in mild hypnosis), or it is done away with through the physician's suggestion just as happens in somnambulism with amnesia" (p. 13).

Although the essential features of this method have been enumerated in the preceding pages, a repetition is unavoidable, and I shall now attempt to show connectedly how far-reaching this method is, its superiority over others, its technique, and its difficulties.

I.

I, for my part, may state that I can adhere to the "Preliminary Communication," but I must confess that after continuous occupation for years with the problems therein touched, I was confronted with new views, as a result of which the former material underwent at least a partial change in grouping and conception. It would be unjust to impute too much of the responsibility for this development to my honored friend, J. Breuer. I therefore take the weight of responsibility upon myself.

In attempting to use Breuer's method of treating hysterical symptoms in a great number of patients by investigation and

ab-reaction in hypnosis, I encountered two obstacles, the pursuit of which led me to change the technique as well as the conception. (1) Not all persons were hypnotizable who undoubtedly showed hysterical symptoms, and in whom there most probably existed the same psychic mechanism. (2) I had to question what essentially characterizes hysteria, and in what it differs from other neuroses.

How I overcame the first difficulty, and what it taught me, I will show later. I will first state what position I have taken in my daily practice towards the second problem. It is very difficult to examine a case of neurosis before it has been subjected to a thorough analysis, such as would result only through the application of Breuer's method. But before we have such a thorough knowledge we are obliged to decide upon the diagnosis and kind of treatment. Hence the only thing remaining for me was to select such cases for the cathartic method which could, for the time being, be diagnosed as hysteria, and which showed some or many stigmata, or the characteristic symptoms of hysteria. Yet it sometimes happened that in spite of the diagnosis of hysteria the therapeutic results were very poor, and even the analysis revealed nothing of importance. At other times I attempted to treat cases which no one took for hysteria by Breuer's method, and I found that I could influence them, and even cure them. Such, for example, was my experience with obsessions, the real obsessions of Westphal's type, cases which did not show a single feature of hysteria. Thus the psychic mechanism revealed in the "Preliminary Communication" could not be pathognomonic of hysteria. Nor could I for the sake of this mechanism throw so many neuroses into the same pot with hysteria. From all the investigated doubts I finally seized upon a plant to treat all the other neuroses in question just like hysteria, to investigate the etiology and the form of psychic mechanisms, and to leave the diagnosis of hysteria to be dependent upon the result of this investigation.

It thus happened that, proceeding from Breuer's methods, I occupied myself mostly with the etiology and the mechanism of the neuroses. After a relatively brief period I was fortunate in obtaining useful results. I then became cognizant of the fact that if we may speak of a reason for the acquirement of neuroses

the etiology must be sought for in the sexual moments. This agrees with the fact that, generally speaking, various sexual moments may also produce various pictures of neurotic disease. Similarly we now venture to employ the etiology for the characteristics of the neuroses, and build up a sharp line of demarcation between the morbid pictures of the neuroses. If the etiological characters constantly agreed with the clinical ones, this was justified.

In this way it was found that neurasthenia really corresponds to a monotonous morbid picture in which, as shown by the analysis, "psychic mechanisms" play no part. From neurasthenia we sharply distinguished the compulsion neurosis (Zwangsneurose) [obsessions, doubts, impulses], the neurosis of the genuine obsessions, in which we can recognize a complicated psychic mechanism, an etiology resembling the one of hysteria, and a far reaching possibility of an involution by psychotherapy. On the other hand it seemed to me undoubtedly imperative to separate from neurasthenia a neurotic symptom complex which depends on a totally divergent, strictly speaking, on a contrary etiology. The partial symptoms of this complex have been recognized by E. Hecker[1] as having a common character. They are either symptoms, or equivalents, or rudiments of anxiety manifestations, and it is for that reason that this complex, so different from neurasthenia, was called by me anxiety neurosis. I maintain that it originates from an accumulation of physical tension which is in turn of a sexual origin. This neurosis, too, has no psychic mechanism, but regularly influences the psychic life, so that among its regular manifestations we have anxious expectation, phobias, hyperesthesias to pain, and other symptoms. This anxiety neurosis, as I take it, certainly corresponds in part to the neurosis called hypochondria, which in some features resembles hysteria and neurasthenia. Yet in none of the earlier works can I consider the demarcation of this neurosis as correct, and moreover, I find that the usefulness of the name hypochondria is impaired by its close relation to the symptom of "nosophobia."

After I had thus constructed for myself the simple picture of neurasthenia, anxiety neuroses, and obsessions, I turned my at-

[1] E. Hecker, Centralblatt für Nervenheilkunde, Dec., 1893.

tention to the commonly occurring cases of neuroses which enter into the diagnosis of hysteria. I now said to myself that it would not do to mark a neurosis as hysterical on the whole, merely because its symptom complex evinced some hysterical signs. I could readily explain this practice by the fact that hysteria is the oldest, the most familiar, and the most striking neurosis under consideration, but still it was an abuse which allowed the placing of many features of perversion and degeneration under the caption of hysteria. Whenever a hysterical symptom, such as anesthesia or a characteristic attack, could he discovered in a complicated case of psychic degeneration, the whole thing was called "hysteria," and hence one could naturally find united under this same trade mark the worst and most contradistory features. As certain as this diagnosis was incorrect it is also certain that our classification must be made from the neurotic standpoint, and as we know neurasthenia, anxiety neurosis, and similar conditions in the pure state, there is no need of overlooking them in combination.

It seemed therefore that the following conception was more warrantable. The neuroses usually occurring are generally to be designated as "mixed." Neurasthenia and anxiety neurosis can be found without effort in pure forms, and most frequently in young persons. Pure cases of hysteria and compulsion neurosis "Zwangsneurose" (obsessions, doubts, impulses) are rare, they are usually combined with an anxiety neurosis. This frequent occurrence of mixed neuroses is due to the fact that their etiological moments are frequently mixed, now only accidentally, and now in consequence of a causal relation between the processes which give rise to the etiological moments of the neuroses. This can be sustained and proven in the individual cases without any difficulty. But it follows from this that it is hardly possible to take hysteria out of connection with the sexual neuroses, that hysteria as a rule presents only one side, one aspect of the complicated neurotic case, and that only, as it were, in the borderline case can it be found and treated as an isolated neurosis. In a series of cases we can perhaps say a potiori fit denominatio.

I shall now examine the cases reported to see whether they speak in favor of my conception of the clinical dependence of

hysteria. Breuer's patient, Anna O.,[2] seems to contradict this and exemplifies a pure hysterical disease. Yet this case which became so fruitful for the knowledge of hysteria was never considered by its observer under the guise of a sexual neurosis and hence cannot at present be utilized as such. When I began to analyze the second patient, Mrs. Emmy v. N., the idea of a sexual neurosis on a hysterical basis was far from my mind. I had just returned from the Charcot school, and considered the connection of hysteria with the sexual theme as a sort of insult—just as my patients were wont to do. But when I today review my notes on this case there is absolutely no doubt that I have to consider it as a severe case of anxiety neurosis with anxious expectations and phobias, which was due to sexual abstinence and was combined with hysteria.

The third case, Miss Lucy R., could perhaps be called the first borderline case of pure hysteria. It is a short episodic hysteria based on an unmistakably sexual etiology. It corresponds to an anxiety neurosis in an over-ripe, amorous girl, whose love was too rapidly awakened through a misunderstanding. Yet the anxiety neurosis could either not be demonstrated or had escaped me. Case IV, Katharina,[3] is really a model of what I have called virginal anxiety; it is a combination of an anxiety neurosis and hysteria, the former produces the symptoms, while the latter repeats them and works with them. At all events, it is a typical case of many juvenile neuroses called "hysteria." Case V, Miss Elisabeth v. R., was again not investigated as a sexual neurosis. I could only suspect that there was a spinal neurasthenia at its basis but I could not confirm it. I must, however, add that since then pure hysterias have become still rarer in my experience. That in grouping together these four cases of hysteria I could disregard in the discussion the decisive factors of sexual neuroses was due to the fact that they were older cases in which I had not as yet carried out the purposed and urgent investigation for the neurotic sexual subsoil. Moreover the reason for my reporting four instead of twelve cases of

[2] See Breuer und Freud, Studien über Hysterie. Deuticke, Leipzig und Wien, 1895, p. 15.

[3] See Breuer und Freud, Studien über Hysterie. Deuticke, Leipzig und Wien, 1895, p. 106.

hysteria, the analysis of which would have confirmed our claims of psychic mechanism for hysterical phenomena, is due to one circumstance, namely that the analysis of these case would have simultaneously revealed them as sexual neuroses, though surely no diagnostician would have denied them the name "hysteria." However, the discussion of such sexual neuroses wiuld have overstepped the limits of our joint publication.

I do not wish to be misunderstood and give the impression that I refuse to accept hysteria as an independent neurotic affection, that I conceive it only as a psychic manifestation of the anxiety neurosis, that I ascribe to it "ideogenous" symptoms only, and that I attribute the somatic symptoms, like hysterogenic points and anesthesias to the anxiety neurosis. None of these statements are true. I believe that hysteria, purified of all admixtures, can be treated independently in every respect except in therapy. For in the treatment we deal with a practical purpose, namely, we have to do away with the whole diseased state, and even if the hysteria occurs in most cases as a component of a mixed neurosis, the case merely resembles a mixed infection where the task is to preserve life, and not merely to combat the effect of one inciting cause of the disease.

I, therefore, find it important to separate the hysterical part in the pictures of the mixed neuroses from neurasthenia, anxiety neurosis, etc., for after this separation I can express concisely the therapeutic value of the cathartic method. I would venture to assert that—principally—it can readily dispose of any hysterical symptom, whereas, as can be easily understood, it is perfectly powerless in the presence of neurasthenic phenomena, and can only seldom, and through detours, influence the psychic results of the anxiety neurosis. Its therapeutic efficacy in the individual case will depend on whether or not the hysterical components of the morbid picture can claim a practical and significant position in comparison to the other neurotic components.

Another limitation placed on the efficacy of the cathartic method we have already mentioned in our "Preliminary Communication." It does not influence the causal determinations of hysteria, and hence it can not prevent the origin of new symptoms in the place of those removed. Hence, on the whole, I must claim a prominent place for our therapeutic method in the realm of the therapy

of neuroses, but I would caution against attaching any importance to it, or putting it into practice outside of this connection. As I am unable to give here a "Therapy of Neuroses" as would be required by the practicing physician, the preceding statements are put on a level with the deferred reference to a later communication; still, for purposes of discussion and elucidation, I can add the following remarks:

1. I do not claim that I have actually removed all the hysterical symptoms which I have undertaken to influence by the cathartic method, but I believe that the obstacles were due to the personal circumstances of the cases, and not to the general principles. In passing sentence, these cases of failure may be left out of consideration, just as the surgeon puts aside all cases who die as a result of narcosis, hemorrhage, accidental sepsis, etc., when deciding upon a new technique. I will again consider the failures of such origin in my later discussions on the difficulties and drawbacks of this method.

2. The cathartic method does not become valueless simply because it is symptomatic and not causal. For a causal therapy is really in most cases only prophylactic; it stops the further progress of the injury, but it does not necessarily remove the products which have already resulted from it. To do this it requires, as a rule, a second agent, and in cases of hysteria the cathartic method is really unsurpassable for such purposes.

3. Where the period of hysterical production, or the acute hysterical paroxysm, has subsided, and the only remnant manifestations left are hysterical symptoms, the cathartic method fulfills all indications, and achieves a full and lasting success. Such a favorable constellation for the therapy does not seldom result on the basis of the sexual life, in consequence of the marked fluctuations in the intensity of the sexual desire and the complications of the required determination for a sexual trauma. Here the cathartic method accomplishes all that is required of it, for the physician can not resolve to change a hysterical constitution. He must rest content if he can remove the disease for which such a constitution shows a tendency, and which can arise through the assistance of external determinants. He must be satisfied if the patient will again become capacitated. Moreover, he can have some hopes for the future, if the possibility of a

relapse be considered, for he knows the main character of the etiology of the neuroses, namely, that their origin is mostly over-determined, and that many moments must unite to produce this result. He can hope that this union will not take place very soon, if individual etiological moments remain in force.

It may be argued that in such subsided cases of hysteria the remaining symptoms would spontaneously disappear without anything else, but this can be answered by the fact that such spontaneous cures very often terminate neither rapidly nor fully, and that the cure will be extraordinarily advanced by the treatment. Whether the cathartic treatment cures only that which is capable of spontaneous recovery, or incidentally also, that which would not cease spontaneously, that question may surely be left open for the present.

4. Where we encounter an acute hysteria during the most acute production of hysterical symptoms, and the consecutive overwhelming of the ego by the morbid products (hysterical psychosis), even the cathartic method will change little the expression and course of the disease. One finds himself in the same position to the neurosis as the doctor to an acute infectious disease. For some time past, now beyond the reach of influence, the etiological moments exerted a sufficient amount of effect, which becomes manifest after overcoming the interval of incubation. The affection can not be warded off, it has to run its course, but meanwhile one must bring about the most favorable conditions for the patient. If during such an acute period one can remove the morbid products, the newly formed hysterical symptoms, it may be expected that their places will be taken by new ones. The physician will not be spared the depressing impression of fruitless effort, the enormous expenditure of exertion, and the disappointment of the relatives, to whom the idea of the necessary duration of time of an acute neurosis is hardly as familiar as in the analogous case of an acute infectious disease; these, and many other things, will probably make most impossible the consequent application of the cathartic method in the assumed case. Nevertheless, it still remains to be considered whether, even in an acute hysteria, the frequent removal of the morbid products does not exercise a curative influence by supporting the

normal ego which is occupied with the defense, and thus preventing it from merging into a psychosis or into ultimate confusion.

That the cathartic method can accomplish something, even in an acute hysteria, and that it can even reduce the new productions of the morbid symptoms quite practically and noticeably, is undoubtedly evident from the case of Anna O., in which Breuer first learned to exercise this process.[4]

5. Where we deal with chronic progressive hysterias with moderate or continued productions of hysterical symptoms, we learn to regret the lack of a causally effective therapy, but we also learn to value the indications of the cathartic method as a symptomatic remedy. We then deal with an injury produced by an etiology which continues to act chronically. We have to strengthen the capacity for resistance of the nervous system of our patient, and we must bear in mind that the existence of an hysterical symptom signifies a weakening of resistance of the nervous system, and represents a predisposing moment. From the mechanism of monosymptomatic hysteria we know that a new hysterical symptom generally originates as an addition to and as an analogy of one already in existence. The location once penetrated represents the weak spot which can be penetrated again. The split off psychic group plays the part of the provoking crystal from which a formerly omitted crystallization emerges with great facility. To remove the already existing symptoms, to do away with the psychic alterations lying at their basis, is the return to the patients the full measure of their resistance capacity, with which they are successfully able to resist the noxious influences. One can do a great deal for the patient by such long continued watchfulness and occasional "chimney-sweeping."

6. I still have to mention the apparent contradiction arising between the admission that not all hysterical symptoms are psychogenic, and the assertion that they can all be removed by psychotherapeutic procedures. The solution lies in the fact that some of these non-psychogenic symptoms, though they represent morbid symptoms, as, for instance, the stigmata, should nevertheless not be designated as affections, and hence it cannot be prac-

[4] See Breuer und Freud, Studien über Hysterie. Deuticke, Leipzig und Wien, 1895, p. 15.

tically noticed even if they remain after the treatment is finished. Other symptoms of a similar nature seem to be taken along indirectly by the psychogenic symptoms, for indirectly they really depend on some psychic causation.

I shall now mention those difficulties and inconveniences of our therapeutic method which are not evident from the preceding histories, or from the following remarks concerning the technique of the method.—I will rather enumerate and indicate than carry them out. The process is toilsome and wearisome for the physician, it presupposes a profound interest for psychological incidents, as well as a personal sympathy for the patient. I could not conceive myself entering deeply into the psychic mechanism of a hysteria in a person who appeared to me common and disagreeable, and who would not, on closer acquaintanceship, be able to awaken in me human sympathy; whereas I can well treat a tabetic or a rheumatic patient regardless of such personal liking. Not less are the requisites on the patient's side. The process is especially inapplicable below a certain niveau of intelligence. It is rendered extremely difficult wherever there is any tinge of weakmindedness. It requires the full consent and the attention of the patients, but, above all, their confidence for the analysis regularly leads to the inmost and most secretly guarded psychic processes. A large proportion of the patients suitable for such treatment withdraw from the physician as soon as they become cognizant whither his investigations tend; to them the physician remains a stranger. In others who have determined to give themseves up to the physician and bestow their confidence upon him, something usually voluntarily given but never demanded, in all those I say, it is hardly avoidable that the personal relation to the physician should not become unduly prominent, at least for some time. Indeed, it seems as if such an influence exerted by the physician is a condition under which alone a solution of the problem is made possible. I do not believe that it makes any essential difference in this condition whether we make use of hypnosis or have to avoid or substitute it. Yet fairness demands that we emphasize the fact that although these inconveniences are inseparable from our method, they, nevertheless, cannot be charged to it. It is much more evident that they are formed

in the preliminary states of the neurosis to be cured, and that they then attach themselves to every medical activity which intensively concerns itself with the patient, and produce in him a psychic change. I could see no harm or danger in the application of hypnosis even in these cases where it was used excessively. The causes for the harm produced lay elsewhere and deeper. When I review the therapeutic efforts of those years since the communications of my honored teacher and friend, J. Breuer, gave me the cathartic method, I believe that I have more often produced good than harm, and brought about some things which could not have been produced by any other therapeutic means. On the whole it was, as expressed in the "Preliminary Communication," "a distinct therapeutic gain."

I must mention still another gain in the application of this method. No severe case of complicated neurosis, with either an excessive or slight tinge of hysteria can better be explained than by subjecting it to an analysis by Breuer's method. In making this analysis I find that whatever shows the hysterical mechanism disappears first, while the rest of the manifestations I meanwhile learn to interpret and refer to their etiology. I thereby gained the essential factors indicated by the instrument of the therapy of the neurosis in question. When I think of the usual differences between my opinion of a case of neurosis before and after such an analysis, I am almost tempted to maintain that the analysis is indispensable for the knowledge of a neurotic disease. I have furthermore made it a practice of applying the cathartic psychotherapy in conjunction with a rest cure, which when required is changed to a full Weir-Mitchell treatment. This advantage lies in the fact that, on the one side I avoid the very disturbing intrusion of new psychic impressions produced during psychotherapy; on the other hand, I exclude the monotony of the Weir-Mitchell treatment, during which the patient not seldom merges into harmful reveries. One might expect that the very considerable psychic labor often imposed upon the patient during the cathartic cure, and the excitement resulting from the reproduction of traumatic events, would run counter to the sense of the Weir-Mitchell rest cure, and would prevent the successes which one is wont to obtain from it. But the contrary happens; through the combination of the Breuer and the Weir-Mitchell therapy, we

obtain all the physical improvements which we expect from the latter, and such marked psychic improvement as never occurs in the rest cure without psychotherapy.

II.

I will now add to my former observations that in attempting to use Breuer's method in greater latitude I met this difficulty—although the diagnosis was hysteria, and the probabilities spoke in favor of the prevalence of the psychic mechanism described by us, yet a number of patients could not be put into the hypnotic state. The hypnosis was necessary to broaden consciousness so as to find the pathogenic reminiscences which do not exist in the ordinary consciousness. I, therefore, was forced to either give up such patients, or to bring about this broadening by other means.

The reason why one person is hypnotizable and another not I could no more explain than others, and hence I could not start on a causal way towards the removal of the difficulties. I also observed that in some patients the obstacle was still more marked, as they even refused to submit to hypnosis. The idea then occurred to me that both cases might be identical, and that in both it might merely be an unwillingness. Those who entertain a psychic inhibition against hypnotism are not hypnotizable, it makes no difference whether they utter their unwillingness or not. It is not fully clear to me whether I can firmly adhere to this conception or not.

It was, therefore, important to avoid hypnotism and yet to obtain the pathogenic reminiscences. Thus I attained in the following manner:

On asking my patients during our first interview whether they remembered the first motive for the symptom in question, some said that they knew nothing, while others thought of something which they designated as an indistinct recollection, yet were unable to pursue it. I then followed Bernheim's example of awakening the apparently forgotten impressions obtained during somnambulism (see the case of Miss Lucy). I urged them by assuring them that they did know it, and that they will recall it, etc., and thus some thought of something, while in others the recollections went further. I became still more pressing, I

ordered the patient to lie down and voluntarily shut his eyes so as to "concentrate" his mind, causing thereby at least a certain similarity to hypnosis, and I then discovered that without any hypnosis there emerged new and retrospective reminiscences which probably belonged to our theme. Through such experiences I gained the impression that through urging alone it would really be possible to bring to light the definitely existing pathogenic series of ideas; and as this urging necessitated much exertion on my part, and showed me that I had to overcome a resistance, I, therefore, formulated this whole state of affairs into the following theory: *Through my psychic work I had to overcome a psychic force in the patient which opposed the pathogenic idea from becoming conscious* (remembered). It then became clear to me that this must really be the same psychic force which assisted in the origin of the hysterical symptom, and at that time prevented the pathogenic idea from becoming conscious. What kind of effective force could here be assumed, and what motive could have brought it into activity? I could easily formulate an opinion, for I already had some complete analyses at my disposal in which I found examples of pathogenic, forgotten, and repressed ideas. From these I could judge the general character of such ideas. They were altogether of a painful nature adapted to provoke the affects of shame, reproach, of psychic pain, and the feeling of injury; they were altogether of that kind which one would not like to experience and prefers to forget.

From all these the thought of defense resulted as if simultaneously. Indeed, it is generally admitted by all psychologists that the assumption of a new idea (assumption in the sense of belief, judgment of reality), depends on the mode and drift of the ideas already united in the ego. For the process of the censor, to which the newly formed ideas are subjected, special technical names have been created. An idea entered into the ego of the patient which proved to be unbearable and evoked a power of repulsion on the part of the ego, the purpose of which was a defense against this unbearable idea. This defense actually succeeded, and the idea concerned was crowded out of consciousness and out of the memory, so that its psychic trace could not apparently be found. Yet this trace must have existed. When I made the effort to direct the attention to it, I perceived as a

resistance the same force which showed itself as repulsion in the genesis of the symptom. If I could now make it probable that the idea became pathogenic in consequence of the exclusion and repression, the chain would seem complete. In many epicrises of our histories, and in a small work concerning the defense neuro-psychoses (1894), I have attempted to indicate the psychological hypotheses with the help of which this connection also—the fact of conversion—can be made clear.

Hence, a psychic force, the repugnance of the ego, has originally crowded the pathogenic idea from the association, and now opposes its return into the memory. The not knowing of the hysterics was really a—more or less conscious—not willing to know, and the task of the therapeutist was to overpower this resistance of association by psychic labor. Such accomplishment is, above all, brought about by "urging," that is, by applying a psychic force in order to direct the attention of the patient on the desired traces of ideas. It does not, however, stop here, but as I will show, it assumes new form in the course of the analysis, and calls to aid more psychic forces.

I shall above all, still linger at "the urging." One cannot go very far with such simple assurances as, "You do know it, just say it," or "It will soon come to your mind." After a few sentences the thread breaks, even in the patient who is in a state of concentration. We must not however, forget that we deal everywhere here with a quantitative comparison, with the struggle between motives of diverse force and intensity. The urging of the strange and inexperienced physician does not suffice for the "association resistance" in a grave hysteria. One must resort to more forceful means.

In the first place I make use of a small technical artifice. I inform the patient that I will in the next moment exert pressure on his forehead, I assure him that during this pressure he will see some reminiscence in the form of a picture, or some thought will occur to him, and I oblige him to communicate to me this picture or this thought, no matter what it may be. He is not supposed to hold it back because he may perhaps think that it is not the desired or the right thing, or because it is too disagreeable to say. There should be neither criticism nor reserve on account of affect or disregard. Only thus could we find the things desired, and

only thus have we unfailingly found them. I then exert pressure for a few seconds on the forehead of the patient lying in front of me, and after stopping the pressure, I ask in a calm tone, as if any disappointment is out of the question, "What have you seen?" or, "What occurred to your mind?"

This method[5] taught me a great deal and led me to the goal every time. Of course I know that I can substitute this pressure on the forehead by any other sign, or any other physical influence, but as the patient lies before me the pressure on the forehead, or the grasping of his head between my two hands, is the most suggestive and most convenient thing that I could undertake for this end. To explain the efficacy of this artifice, I may perhaps say that it corresponds to a "momentary reenforced hypnosis"; but the mechanism of hypnosis is so enigmatical to me that I would not like to refer to it as an explanation. I rather think that the advantage of the process lies in the fact that through it I dissociate the attention of the patient from his conscious quest and reflection, in brief, from everything upon which his will can manifest itself. This resembles the process of staring at a crystal globe, etc. The fact, that under the pressure of my hand there always appears that which I am looking for teaches that the supposedly forgotten pathogenic ideas always lie ready, "close by," being attainable through easily approachable associations, and all that is necessary is to clear away some obstacle. This obstacle again seems to be the person's will, and different persons learn to discard their premeditations and to assume a perfectly objective attitude toward the psychic processes within them.

It is not always a "forgotten" reminiscence which comes to the surface under the pressure of the hand; in the rarest cases the real pathogenic reminiscences can be superficially discovered. More frequently an idea comes to the surface which is a link between the starting idea and the desired pathogenic one of the association chain, or it is an idea forming the starting point of a new series of thoughts and reminiscences, at the end of which the pathogenic idea exists. The pressure, therefore, has really not revealed the pathogenic idea, which, if torn from its connections without any preparation, would be incomprehensible; but it has

[5] As mentioned in the preface the author has long since discarded this pressure procedure.—Translator's note.

shown the way to it, and indicated the direction towards which the investigation must proceed. The idea which is at first awakened through the pressure may correspond to a familiar reminiscence which was never repressed. If the connection becomes torn on the road to the pathogenic idea, all that is necessary for the reproduction of a new orientation and connection is a repetition of the procedure, that is, of the pressure.

In still other cases the pressure of the hand awakens a reminiscence well known to the patient, which appearance, however, causes him surprise because he had forgotten its relation to the starting idea. In the further course of the analysis this relation becomes clear. From all these results of the pressure one receives a delusive impression of a superior intelligence external to the patient's consciousness, which systematically holds a large psychic material for definite purposes, and has provided an ingenious arrangement for its return into consciousness. I presume, however, that this unconscious second intelligence is really only apparent.

In every complicated analysis one works repeatedly, nay continuously, with the help of this procedure (pressure on the forehead), which leads us from the place where the patient's conscious reconductions become interrupted, showing us the way over reminiscences which remained known, and calling our attention to connections which have merged into forgetfulness. It also evokes and connects memories which have for years been withdrawn from the association, but can still be recognized as memories; and finally, as the highest performance of reproduction, it causes the appearance of thoughts which the patient never wishes to recognize as his own, which he does not remember, although he admits that they are inexorably demanded by the connection, and is convinced that just these ideas cause the termination of the analysis and the cessation of the symptoms.

I will now attempt to give a series of examples showing the excellent achievements of this procedure. I treated a young lady who suffered for six years from an intolerable and protracted nervous cough, which apparently was nurtured by every common catarrh, but must have had its strong psychic motives. Every other remedy had long since shown itself to be powerless, and I therefore attempted to remove the symptom by psycho-

analysis. All that she could remember was that the nervous cough began at the age of fourteen while she boarded with her aunt. She remembered absolutely no psychic excitement during that time, and did not believe that there was a motive for her suffering. Under the pressure of my hand, she at first recalled a large dog. She then recognized the memory picture; it was her aunt's dog which was attached to her, and used to accompany her everywhere, and without any further aid it occurred to her that this dog died and that the children buried it solemnly; and on the return from this funeral her cough appeared. I asked her why she began to cough, and after helping her with the pressure, the following thought occurred to her: "Now I am all alone in this world; no one loves me here; this animal was my only friend, and now I have lost it." She then continued her story. "The cough disappeared when I left my aunt, but reappeared a year and a half later."—"What was the reason for it?" —"I do not know."—I again exerted some pressure on the forehead, and she recalled the news of her uncle's death during which the cough again manifested itself, and also recalled a train of thought similar to the former. The uncle was apparently the only one in the family who sympathized with and loved her. That was, therefore, the pathogenic idea: "People do not love her; everybody else is preferred; she really does not deserve to be loved," etc. To the idea of love there clung something which caused a marked resistance to the communication. The analysis was interrupted before this explanation.

Some time ago I attempted to relieve an elderly lady of her anxiety attacks, which considering their characteristic qualities, were hardly adapted to such influence. Since her menopause she had become extremely religious, and always received me as if I were the Devil. She was always armed with a small ivory crucifix which she hid in her hand. Her attacks of anxiety, which bore the hysterical character, could be traced to her early girlhood, and were supposed to have originated from the application of an iodine preparation used to reduce a moderate swelling of the thyroid. I naturally repudiated this origin, and sought to substitute it by another which was in better harmony with my views concerning the etiology of neurotic symptoms. To the first

question for an impression of her youth which would stand in causal connection to the attacks of anxiety, there appeared under the pressure of my hand the reminiscence of reading a so called devotional book wherein piously enough there was some mention of the sexual processes. The passage in question made an impression on this girl, which was contrary to the intention of the author. She burst into tears and flung the book away. That was before the first attack of anxiety. A second pressure on the forehead of the patient evoked the next reminiscence, it referred to her brother's teacher who showed her great respect, and for whom she entertained a warmer feeling. This reminiscence culminated in the reproduction of an evening in her parents' home during which they all sat around the table with the young man, and delightfully enjoyed themselves in a lively conversation. During the night following this evening she was awakened by the first attack of anxiety which surely had more to do with some resistance against a sensual feeling than perhaps with the coincidently used iodine. In what other way could I have succeeded in revealing in this obstinate patient, prejudiced against me and every worldly remedy, such a connection contrary to her own opinion and assertion?

On another occasion I had to deal with a young happily married woman, who as early as in the first years of her girlhood, was found every morning for some time in a state of lethargy, with rigid members, opened mouth, and protruding tongue. Similar attacks, though not so marked, recurred at the present time on awakening. A deep hypnosis could not be produced, so that I began my investigation in a state of concentration, and assured her during the first pressure that she would see something that would be directly connected with the cause of her condition during her childhood. She acted calmly and willingly, she again saw the residence in which she had passed her early girlhood, her room, the position of her bed, the grandmother who lived with them at the time, and one of her governesses whom she dearly loved. There was then a succession of small, quite indifferent scenes, in these rooms, and among these persons, the conclusion of which was the leave taking of the governess who married from the home. I did not know what to start with these reminiscences;

I could not bring about any connection between them and the etiology of the attacks. To be sure the various circumstances were recognized as having occurred at the same time at which the attacks first appeared.

Before I could continue the analysis, I had occasion to talk to a colleague, who, in former years, was my patient's family physician. From him I obtained the following explanation: At the time that he treated the mature and physically very well developed girl for these first attacks, he was struck by the excessive affection in the relations between her and her governess. He became suspicious and caused the grandmother to watch these relations. After a short while the old lady informed him that the governness was wont to pay nightly visits to the child's bed, and that quite regularly after such visits the child was found in the morning in an attack. She did not hesitate to bring about the quiet removal of this corruptress of youth. The children, as well as the mother, were made to believe that the governness left the house in order to get married.

The treatment, which was above all successful, consisted in informing the young woman of the explanations given to me.

Occasionally the explanations, which one obtains by the pressure procedure, follow in very remarkable form, and under circumstances which make the assumption of an unconscious intelligence appear even more alluring. Thus I recall a lady who suffered for years from obsessions and phobias, and who referred the origin of her trouble to her childhood, but could mention nothing to which it could have been attributed. She was frank and intelligent, and evinced only a very slight conscious resistance. I will add here that the psychic mechanism of obsessions is very closely related to that of hysterical symptoms, and that the technique of the analysis in both is the same.

On asking the lady whether she had seen or recalled anything under the pressure of my hand, she answered, "Neither, but a word suddenly occurred to me."—"A single word?"—"Yes, but it is too foolish."—"Just tell it."—"Teacher."—"Nothing more?" —"No." I exerted pressure a second time, and again a single word flashed through her mind: "Shirt."—I now observed that we have dealt with a new mode of replying, and by repeated pres-

sure I evoked the following apparently senseless series of words: Teacher—shirt—bed—city—wagon. I asked, "What does all that mean?" She reflected for a moment, and it then occurred to her that "it can only refer to this one incident which now comes to my mind. When I was ten years old my older sister of twelve had an attack of frenzy one night, and had to be bound, put in a wagon and taken to the city. I remember distinctly that it was the teacher who overpowered her and accompanied her to the asylum."—We then continued this manner of investigation, and received from our oracle another series of words which, though we could not altogether interpret, could nevertheless be used as a continuation of the story, and as an appendix to a second. The significance of this reminiscence was soon clear. The reason why her sister's illness made such an impression on her was because they both shared a common secret. They slept in the same room, and one night they both submitted to a sexual assault by a certain man. In discovering this sexual trauma of early youth, we revealed not only the origin of the first obsession but also the trauma which later acted pathogenically.—The peculiarity of this case lies only in the appearance of single catch words which we had to elaborate into sentences, for the irrelevance and incoherence found in these oracle like uttered words adhere to all ideas and scenes which generally occur as a result of pressure. On further investigation it is regularly found that the seemingly disconnected reminiscences are connected by close streams of thought, and that they lead quite directly to the desired pathogenic moment.

With pleasure do I therefore recall a case of analysis in which my confidence in the results of pressure was splendidly justified. A very intelligent, and apparently very happy, young woman consulted me for persistent pain in her abdomen which yielded to no treatment. I found that the pain was situated in the abdominal wall and was due to palpable muscular hardening, and I ordered local treatment.

After months I again saw the patient who said that "the former pain disappeared after following the treatment and remained away a long time, but now it has reappeared as a nervous pain. I recognize it by the fact that I do not perceive it now on motion as before, but only during certain hours, as for example,

in the morning on awakening, and during certain excitements." The patient's diagnosis was quite correct. It was now important to discover the cause of this pain, but in this she could not assist me in her uninfluenced state. When, in a state of concentration and under the pressure of my hand, I asked her whether anything occurred to her, or whether she saw anything, she began to describe her visual pictures. She saw something like a sun with rays, which I naturally had to assume to be a phosphene produced by pressure on the eyes. I expected that the useful pictures would follow, but she continued to see stars of a peculiar pale blue light, like moonlight, etc., and I believed that she merely saw glittering, shining, and twinkling spots before the eyes. I was already prepared to add this attempt to the failures, and I was thinking how I could quietly withdraw from this affair, when my attention was called to one of the manifestations which she described. She saw a big black cross which was inclined, the edges of which were surrounded by a subdued moonlike light in which all the pictures thus far seen were shining, and upon the arm there flickered a little flame that was apparently no longer a phosphene. I continued to listen. She saw numerous pictures in the same light, peculiar signs resembling somewhat sanscrit. She also saw figures like triangles, among which there was one big triangle, and again the cross. I now thought of an allegorical interpretation, and asked, "What does this cross mean?"—"It is probably meant to interpret pain," she answered. I argued, saying, that "by cross one usually understands a moral burden," and asked her what was hidden behind that pain. She could not explain that and continued looking. She saw a sun with golden rays which she interpreted as God, the primitive force; she then saw a gigantic lizard which she examined quizzically but without fear; then a heap of snakes, then another sun but with mild silvery rays, and in front of it, between her own person and this source of light, there was a barrier which concealed from her the center of the sun.

I knew for some time that we dealt here with allegories, and I immediately asked for an explanation of the last picture. Without reflecting she answered: "The sun is perfection, the ideal, and the barrier represents my weaknesses and failings which stand between me and the ideal."—"Indeed, do you re-

proach yourself? Are you dissatisfied with yourself?"—"Yes." —"Since when?"—"Since I became a member of the Theosophical Society and read the writings edited by it. I have always had a poor opinion of myself."—"What was it that made the last strongest impression upon you?"—"a translation from the sanscrit which now appears in serial numbers." A minute later I was initiated into her mental conflicts, and into her self reproaches. She related a slight incident which gave occasion for a reproach, and in which, as a result of an inciting conversion, the former organic pain at first appeared. The pictures which I had at first taken for phosphenes were symbols of occultistic streams of thought, perhaps plain emblems from the title pages of occultistic books.

I have thus far so warmly praised the achievements of the pressure procedure, and have so entirely neglected the aspect of the defense or the resistance, that I certainly must have given the impression that by means of this small artifice one is placed in position to became master of the psychic resistances against the cathartic cure. But to believe this would be a gross mistake. Such advantages do not exist in the treatment so far as I can see; here, as everywhere else, great change requires much effort. The pressure procedure is nothing but a trick serving to surprise for awhile the defensive ego, which in all graver cases recalls its intentions and continues its resistance.

I need only recall the various forms in which this resistance manifested itself. In the first place, the pressure experiment usually fails the first or second time. The patient then expresses himself disappointed, saying, "I believed that some idea would occur to me, but I only thought so; as attentive as I was nothing came." Such attitudes assumed by the patient are not yet to be counted as a resistance; we usually answer to that, "You were really too anxious, the second time things will come." And they really come. It is remarkable how completely the patients—even the most tractable and the most intelligent—can forget the agreement which they have previously entered into. They have promised to tell everything that occurs to them under the pressure of the hand, be it closely related to them or not, and whether it is agreeable to them to say it or not; that is, they are to tell every-

thing without any choice, or influence by critique or affect. Yet they do not keep their promise, it is apparently beyond their powers. The work repeatedly stops, they continue to assert that this time nothing came, to their mind. One needs not believe them, and one must always assume, and also say, that they hold back something because they believe it to be unimportant, or perceive it as painful. One must insist, repeat the pressure, and assume an assured attitude until one really hears something. The patient then adds, "I could have told you that the first time."—"Why did you not say it?"—"I could not believe that that could be it. Only after it returned repeatedly have I decided to tell it"; or, "I had hoped that it would not be just that, that I could spare myself from saying it, but only after it could not be repressed have I noticed that I could not avoid it."—Thus the patient subsequently betrays the motives of a resistance which he did not at first wish to admit. He apparently could not help offering resistances.

It is remarkable under what subterfuges these resistances are frequently hidden. "I am distracted today"; "the clock or the piano playing in the next room disturbs me," they say. I became accustomed to answer to that, "Not at all, you simply struck against something that you do not willingly wish to say. That does not help you at all. Just stick to it."—The longer the pause between the pressure of my hand and the utterance of the patient, the more suspicious I become, and the more is it to be feared that the patient arranges what comes to his mind, and distorts it in the reproduction. The most important explanations are frequently ushered in as superfluous accessories, just as the princes of the opera who are dressed as beggars. "Something now occurred to me, but it has nothing to do with it. I only tell it to you because you wish to know everything." With this introduction we usually obtain the long desired solution. I always listen when I hear a patient talk so lightly of an idea. That the pathogenic idea should appear of so little importance on its reappearance is a sign of the successful defense. One can infer from this of what the process of defense consisted. Its object was to make a weak out of a strong idea, that is, to rob it of its affect.

Among other signs the pathogenic memories can also be recognized by the fact that they are designated by the patient as unes-

sential, and yet are only uttered with resistance. There are also cases where the patient seeks to disavow the recollections, even while they are being reproduced, with such remarks as these: "Now something occurred to me, but apparently you talked it into me"; or, "I know what you expect to this question, you surely think that I thought of this and that." An especially clever way of shifting is found in the following expression: "Now something really occurred to me, but it seems to me as if I added it, and that it is not a reproduced thought."—In all these cases I remain inflexibly firm, I admit none of these distinctions, but explain to the patient that these are only forms and subterfuges of the resistance against the reproduction of a recollection which in spite of all we are forced to recognize.

One generally experiences less trouble in the reproduction of pictures than thoughts. Hysterical patients who are usually visual are easier to manage than patients suffering from obsessions. Once the picture emerges from the memory we can hear the patient state that as he proceeds to describe it, it proportionately fades away and becomes indistinct; the patient wears it out, so to speak, by transforming it into words. We then orient ourselves through the memory picture itself in order to find the direction towards which the work should be continued. We say to the patient, "Just look again at the picture, has it disappeared?" —"As a whole, yes, but I still see this detail."—"Then this must have some meaning, you will either see something new, or this remnant will remind you of something." When the work is finished the visual field becomes free again, and a new picture can be called forth; but at other times such a picture, in spite of its having been described, remains persistently before the inner eye of the patient, and I take this as a sign that he still has something important to tell me concerning its theme. As soon as this his been accomplished, the picture disappears like a wandering spirit returning to rest.

It is naturally of great value for the progress of the analysis to carry our point with the patient, otherwise we have to depend on what he thinks is proper to impart. It, therefore, will be pleasant to hear that the pressure procedure never failed except in a single case which I shall discuss later, but which I can now characterize by the fact that there was a special motive for the

resistance. To be sure, it may happen under certain conditions that the procedure may be applied without bringing anything to light; as, for example, we may ask for the further etiology of a symptom when the same has already been exhausted; or, we may investigate for the psychic genealogy of a symptom, perhaps a pain, which really was of somatic origin. In these cases the patient equally insists that nothing occurred to him, and he is right. We should strive to avoid doing an injustice to the patient by making it a general rule not to lose sight of his features while he calmly lies before us during the analysis. One can then learn to distinguish, without any difficulty, the psychic calm in the real non appearance of a reminiscence from the tension and emotional signs under which the patient labors in trying to disavow the emerging reminiscences for the purpose of defense. The differential diagnostic application of the pressure procedure is really based on such experiences.

We can see, therefore, that even with the help of the pressure procedure the task is not an easy one. The only advantage gained is the fact that we have learned from the results of this method in what direction to investigate, and what things we have to force upon the patient. For some cases that suffices, for the question is really to find the secret, and tell it to the patient, so that he is usually then forced to relinquish his resistance. In other cases more is necessary; here the surviving resistance of the patient manifests itself by the fact that the connections become torn, the solutions do not appear, and the recalled pictures come indistinctly and incompletely. On reviewing, at a later period, the earlier results of an analysis, we are often surprised at the distorted aspects of all the occurrences and scenes which we have snatched from the patient by the pressure procedure. It usually lacks the essential part, the relations to the person or to the theme, and for that reason the picture remained incomprehensible. I will now give one or two examples showing the effects of such a censoring during the first appearance of the pathogenic memories. The patient sees the upper part of a female body on which a loose covering fits carelessly, only much later he adds to this torso the head, and thereby betrays a person and a relationship. Or, he relates a reminiscence of his childhood about two boys whose forms are very indistinct, and to whom a certain mis-

chievousness was attributed. It required many months and considerable progress in the course of the analysis before he again saw this reminiscence and recognized one of the children as himself and the other as his brother. What means have we now at our disposal to overcome this continued resistance?

We have but few, yet we have almost all those by which one person exerts a psychic influence on the other. In the first place we must remember that psychic resistance, especially of long continuance, can only be broken slowly, gradually, and with much patience. We can also count on the intellectual interest which manifests itself in the patient after a brief period of the analysis. On explaining and imparting to him the knowledge of the marvelous world of psychic processes, which we have gained only through such analysis, we obtain his collaboration, causing him to view himself with the objective interest of the investigator, and we thus drive back the resistance which rests on an affective basis. But finally—and this remains the strongest motive force—after the motives for the defense have been discovered, we must make the attempt to reduce or even substitute them by stronger ones. Here the possibility of expressing the therapeutic activity in formulæ ceases. One does as well as he can as an explainer where ignorance has produced timorousness, as a teacher, as a representative of a freer and more superior world-conception, and as confessor, who through the continuance of his sympathy and his respect, imparts, so to say, absolution after the confession. One endeavors to do something humane for the patient in so far as the range of one's own personality and the measure of sympathy which one can set apart for the case allows. It is an indispensable prerequisite for such psychic activities to have approximately discovered the nature of the case and the motives of the defense here effective. Fortunately the technique of the urging and the pressure procedure take us just so far. The more we have solved such enigmas the easier will we discover new ones, and the earlier will we be able to manage the actual curative psychic work. For it is well to bear in mind that although the patient can rid himself of an hysterical symptom only after reproducing and uttering under emotion its causal pathogenic impressions, yet the therapeutic task merely consists in inducing him to do it, and once the task has

been accomplished there remains nothing for the doctor to correct or abolish. All the contrary suggestions necessary have already been employed during the struggle carried on against the resistance. The case may be compared to the unlocking of a closed door, where, as soon as the door knob has been pressed downward, no other difficulties are encountered in opening the door.

Among the intellectual motives employed for the overcoming of the resistance one can hardly dispense with one affective moment, that is, the personal equation of the doctor, and in a number of cases this alone will be able to break the resistance. The conditions here do not differ from those found in any other branch of medicine, and one should not expect any therapeutic method to fully disclaim the assistance of this personal moment.

III.

In view of the discussions in the preceding section concerning the difficulty of my technique, which I have unreservedly exposed, —I have really collected them from my most difficult cases, though it will often be easier work—in view then of this state of affairs everybody will wish to ask whether it would not be more suitable, instead of all these tortures, to apply oneself more energetically to hypnosis, or to limit the application of the cathartic method to only such cases as can be placed in deep hypnosis. To the latter proposition I should have to answer that the number of patients available for my skill would shrink considerably, but to the former advice I will advance the supposition that even where hypnosis could be produced the resistance would not be very much lessened. My experiences in this respect are not particularly extensive, so that I am unable to go beyond this supposition, but wherever I achieved a cathartic cure in the hypnotic state I found that the work devolved upon me was not less than in the state of concentration. I have only recently finished such a treatment during which course I caused the disappearance of a hysterical paralysis of the legs. The patient merged into a state, psychically very different from the conscious, and somatically distinguished by the fact that she was unable to open her eyes or rise without my ordering her to do so; and still I never had a case showing greater resistance than this one. I placed no value on these phy-

sical signs, and toward the end of the ten months' treatment they really became imperceptible. The condition of the patient during our work has therefore lost nothing of its psychic peculiarities, such as the ability to recall the unconscious and its very peculiar relation to the person of the physician. To be sure, in the history of Mrs. Emmy v. N. I have described an example of a cathartic cure accomplished in a profound somnambulism in which the resistance played almost no part. But nothing that I obtained from this woman would have required any special effort; I obtained nothing that she could not have told me in her waking state after a longer acquaintanceship and some esteem. The real causes of her disease, which were surely identical with the causes of her relapses after my treatment, I have never found—it was my first attempt in this therapy—and when I once asked her accidentally for a reminiscence which contained a fragment of the erotic, I found her just as resistant and unreliable in her statements as any one of my later non-somnambulic patients. This patient's resistance, even in the somnambulic state, against other requirements and exactions I have already discussed in her history. Since I have witnessed cases who, even in deep somnambulism were absolutely refractory therapeutically despite their obedience in everything else, I really became skeptical as to the value of hypnosis for the facilitation of the cathartic treatment. A case of this kind I have reported in brief,[6] and could still add others.

In our discussion thus far, the idea of resistance has thrust itself to the foreground. I have shown how, in the therapeutic work, one is led to the conception that hysteria originates through the repression of an unbearable idea from a motive of defense, that the repressed idea remains as a weak (mildly intensive) reminiscence, and that the affect snatched from it is used for a somatic innervation, that is, conversion of the excitement. By virtue of its repression the idea becomes the cause of morbid symptoms, that is, pathogenic. A hysteria showing this psychic mechanism may be designated by the name of "defense-hysteria," but both Breuer and myself have repeatedly spoken of two other kinds of hysterias which we have named hypnoid- and retention-

[6] See Breuer und Freud, Studien über Hysterie. Deuticke, Leipzig und Wien, 1895, p. 85.

hysteria. The first to reveal itself to us was really the hypnoid-hysteria, for which I can mention no better example than Breuer's case of Miss Anna O.[7] For this form of hysteria Breuer gives an essentially different psychic mechanism than for the form which is characterized by conversion. Here the idea becomes pathogenic through the fact that it is conceived in a peculiar psychic state, having remained from the very beginning external to the ego. It therefore needs no psychic force to keep it away from the ego, and it need not awaken any resistance when, with the help of the somnambulic psychic authority, it is initiated into the ego. The history of Anna O. really shows no such resistance.

I held this distinction as so essential that it has readily induced me to adhere to the formation of the hypnoid-hysteria. It is however remarkable that in my own experience I encountered no genuine hypnoid-hysteria, whatever I treated changed itself into a defense hysteria. Not that I have never dealt with symptoms which manifestly originated in separated conscious states, and therefore were excluded from being accepted into the ego. I found this also in my own cases, but I could show that the so called hypnoid state owed its separation to the fact that a split-off psychic group originated before, through defense. In brief, I cannot suppress the suspicion that hypnoid and defense hysteria meet somewhere at their roots, and that the defense is the primary thing; but I know nothing about it.

Equally uncertain is at present my opinion concerning the retention hysteria in which the therapeutic work is also supposed to follow without any resistance. I had a case which I took for a typical retention hysteria, and I was pleased over the anticipation of an easy and certain success; but this success did not come as easy as the work really was. I therefore presume, and again with all caution appropriate to ignorance, that in retention hysteria, too, we can find at its basis a fragment of defense which has thrust the whole process into hysteria. Let us hope that new experiences will soon decide whether I am running into the danger of one-sidedness and error in my tendency to spread the conception of defense for the whole of hysteria.

Thus far I have dealt with the difficulties and technique of the

[7] l. c., p. 15.

cathartic method, I would now like to add a few indications showing how one makes an analysis with technique. For me this is a very interesting theme, but I do not expect that it will excite similar interest in others who have not practiced such analyses. Properly speaking we shall again deal with the technique, but this time with those difficulties concerning which the patient cannot be held responsible, and which must in part be the same in a hypnoid and a retention hysteria as well as in the defense hysteria which I have in mind as a model. I start on this last fragment of discussion with the expectation that the psychic peculiarities revealed here might sometimes attain a certain value as raw material for an intellectual dynamics.

The first and strongest impression which one gains through such an analysis is surely the fact that the pathogenic psychic material, apparently forgotten and not at the disposal of the ego, playing no rôle in the association and in memory, still lies ready in some manner and in proper and good order. All that is necessary is to remove the resistances blocking the way. Barring that, everything is known as we know anything else, the proper connections of the individual ideas among themselves and with the nonpathogenic are frequently recalled and are present; they have been produced in their time and retained in memory. The pathogenic psychic material appears as the property of an intelligence which is not necessarily inferior to the normal ego. The semblance of a second personality is often most delusively produced. Whether this impression is justified, whether the arrangements of the psychic material resulting after the adjustment is not transferred back into the time of the disease, these are questions which I do not like to consider in this place. One cannot easily and intuitively describe the experiences resulting from these analyses as if he placed himself in the position, which one can only take a survey of after their disappearance.

The condition is usually not so simple as one represents it in special cases, as, for example, in a single case in which a symptom originates through a serious trauma. We frequently deal not with a single hysterical symptom but with a number of the same which are partially independent of one another and partially connected. We must not expect a single traumatic reminiscence whose nucleus is a single pathogenic idea, but we must be ready to assume

a series of partial traumas and a concatenation of pathogenic streams of thought. The monosymptomatic traumatic hysteria is, as it were, an elementary organism, it is a single being in comparison to the complicated structure of a grave hysterical neurosis as is generally encountered.

The psychic material of such hysteria presents itself as a multidimensional formation of at least triple stratification. I hope to be able to soon justify this figurative expression. First of all there is a nucleus of such reminiscences (either experiences or streams of thought) in which the traumatic moment culminated, or in which the pathogenic idea has found its purest formation. Around this nucleus we often find an incredibly rich mass of other memory material which we have to elaborate by the analysis in the triple arrangement mentioned before. In the first place, there is an unmistakable linear chronological arrangement which takes place within every individual theme. As an example of this I can only cite the arrangement in Breuer's analysis of Anna O. The theme is that of becoming deaf, of not hearing,[8] which then becomes differentiated according to seven determinants, and under each heading there were from ten to one hundred single reminiscences in chronological order. It was as if one should take up an orderly kept record. In the analysis of my patient, Emmy v. N., there were similar if not so many memory subdivisions; they formed quite a general event in every analysis. They always occurred in a chronological order which was as definitely reliable as the serial sequences of the days of the week or the names of the months in psychically normal individuals. They increased the work of the analysis through the peculiarity of reversing the series of their origin in the reproduction; the freshest and the most recent occurrence of the accumulation occurred first as a "wrapper," and that with which the series really began gave the impression of the conclusion.

The grouping of similar reminiscences in a multiplicity of linear stratifications, as represented in a bundle of documents, in a package, etc., I have designated as the formation of a theme. These themes now show a second form of arrangement. I cannot express it differently than by saying that they are con-

[8] See Breuer und Freud, Studien über Hysterie. Deuticke, Wien und Leipzig, 1895, p. 28.

centrically stratified around the pathogenic nucleus. It is not difficult to say what determines these strata, and according to what decreasing or increasing magnitude this arrangement follows. They are layers of equal resistance tending towards the nucleus, accompanied by zones of similar alteration of consciousness into which the individual themes extend. The most peripheral layers contain those reminiscences (or fascicles) of the different themes which can readily be recalled and were always perfectly conscious. The deeper one penetrates the more difficult it becomes to recognize the emerging reminiscences until one strikes those near the nucleus which the patient disavows, even at the reproduction.

As we shall hear later it is the peculiarity of the concentric stratification of the pathogenic psychic material which gives to the course of such an analysis its characteristic features. We must now mention the third and most essential arrangement concerning which a general statement can hardly be made. It is the arrangement according to the content of thought, the connection through the logical thread reaching to the nucleus which might in each case correspond to a special, irregular, and manifoldly devious road. This arrangement has a dynamic character in contradistinction to both morphological stratifications mentioned before. Whereas, in a specially formed scheme the latter would be represented by rigid, arched, and straight lines, the course of the logical concatenation would have to be followed with a wand, over the most tortuous route, from the superficial into the deep layers and back, generally, however, progressing from the peripheral to the central nucleus, and touching thereby all stations; that is, its movement is similar to the zigzag movement of the knight in the solution of a chess problem.

I will still adhere for a moment to the last comparison in order to call attention to a point in which it does not do justice to the qualities of the thing compared. The logical connection corresponds not only to a zigzag-like devious line, but rather to a ramifying and especially to a converging system of lines. It has a junction in which two or more threads meet only to proceed thence united, and, as a rule, many threads running independently, or here and there connected by by-paths, open into the nucleus. To put it in different words, it is very remarkable how frequently a symptom is manifoldly determined, that is, over-determined.

I will introduce one more complication, and then my effort to illustrate the organization of the pathogenic psychic material will be achieved. It can happen that we may deal with more than one single nucleus in the pathogenic material, as, for example, when we have to analyze a second hysterical outbreak having its own etiology but which is still connected with the first outbreak of an acute hysteria which has been overcome years before. It can readily be imagined what strata and streams of thought must be added in order to produce a connection between the two pathogenic nuclei.

I will still add a few observations to the picture obtained of the organization of the pathogenic material. We have said of this material that it behaves like a foreign body, and that the therapy also acts like the removal of a foreign body from the living tissues. We are now in position to consider the shortcomings of this comparison. A foreign body does not enter into any connection with the layers of tissue surrounding it, although it changes them and produces in them a reactive inflammation. On the other hand, our pathogenic psychic group does not allow itself to be cleanly shelled out from the ego, its outer layers radiate in all directions into the parts of the normal ego, and really belong to the latter as much as to the pathogenic organization. The boundaries between both become purely conventional in the analysis, being placed now here, now there, and in certain locations no demarcation is possible. The inner layers become more and more estranged from the ego without showing a visible beginning of the pathogenic boundaries. The pathogenic organization really does not behave like a foreign body, but rather like an infiltration. The infiltrate must, in this comparison, be assumed to be the resistance. Indeed, the therapy does not consist in extirpating something—psychotherapy cannot do that at present—but it causes a melting of the resistance, and thus opens the way for the circulation into a hitherto closed territory.

(I make use here of a series of comparisons all of which have only a very limited resemblance to my theme, and do not even agree among themselves. I am aware of that, and I am not in danger of over-estimating their value; but, as it is my intention to illustrate the many sides of a most complicated and not as yet depicted idea, I therefore take the liberty of dealing also in the

following pages with comparisons which are not altogether free from objections.)

If, after a thorough adjustment, one could show to a third party the pathogenic material in its present recognized, complicated and multidimensional organization, he would justly propound the question, "How could such a camel go through the needle's eye?" Indeed, one does not speak unjustly of a "narrowing of consciousness." The term gains in sense and freshness for the physician who accomplishes such an analysis. Only one single reminiscence can enter into the ego-consciousness; the patient occupied in working his way through this one sees nothing of that which follows, and forgets everything that has already wedged its way through. If the conquest of this one pathogenic reminiscence strikes against impediments, as, for example, if the patient does not yield the resistance against it, but wishes to repress or distort it, the strait is, so to speak, blocked; the work comes to a standstill, it cannot advance, and the one reminiscence in the breach confronts the patient until he takes it up into the breadth of his ego. The whole spacially extended mass of the pathogenic material is thus drawn through a narrow fissure and reaches consciousness as if disjointed into fragments or strips, and it is the task of the psychotherapist to recompense it into the conjectured organization. He who desires still more comparisons may think here of a Chinese puzzle.

If one is about to begin an analysis in which one may expect such an organization of the pathogenic material, the following results of experience may be useful: *It is perfectly hopeless to attempt to make any direct headway towards the nucleus of the pathogenic organization.* Even if it could be guessed the patient would still not know what to start with the explanation given to him, nor would it change him psychically.

There is nothing left to do but follow up the periphery of the pathogenic psychic formation. One begins by allowing the patient to relate and recall what he knows, during which one can already direct his attention, and through the application of the pressure procedure slight resistances may be overcome. Whenever a new way is opened through pressure it can be expected that the patient will continue it for some distance without any new resistance.

After having worked for a while in such manner a coöperating activity is usually manifested in the patient. A number of reminiscences now occur to him without any need of questioning or setting him a task. A way has thus been opened into an inner stratum, within which the patient now spontaneously disposes of the material of equal resistance. It is well to allow him to reproduce for a while without being influenced; of course, he is unable to reveal important connections, but he may be allowed to clear things within the same stratum. The things which he thus reproduces often seem disconnected, but they give up the material which is later revived by the recognized connections.

One has to guard here in general against two things. If the patient is checked in the reproduction of the inflowing ideas, something is apt to be "buried" which must be uncovered later with great effort. On the other hand one must not overestimate his "unconscious intelligence," and one must not allow it to direct the whole work. If I should wish to schematize the mode of labor, I could perhaps say that one should himself undertake the opening of the inner strata and the advancement in the radial direction, while the patient should take care of the peripheral extension.

The advancement is brought about by the fact that the resistance is overcome in the manner indicated above. As a rule, however, one must at first solve another problem. One must obtain a piece of a logical thread by which direction alone one can hope to penetrate into the interior. One should not expect that the voluntary information of the patient, the material which is mostly in the superficial strata, will make it easy for the analyzer to recognize the locations where it enters into the deep, and to which points the desired connections of thought are attached. On the contrary, just this is cautiously concealed, the assertion of the patient sounds perfect and fixed in itself. One is at first confronted, as it were, by a wall which shuts off every view, and gives no suggestion of anything hidden behind it.

If, however, one views with a critical eye the assertion obtained from the patient without much effort and resistance, one will unmistakably discover in it gaps and injuries. Here the connection is manifestly interrupted and is scantily completed by the patient by an expression conveying quite insufficient information. Here

one strikes against a motive which in a normal person would be designated as flimsy. The patient refuses to recognize these gaps when his attention is called to them. The physician, however, does well to seek under these weak points access to the material of the deeper layers and to hope to discover just here the threads of the connections which he traces by the pressure procedure. One, therefore, tells the patient, "You are mistaken, what you assert can have nothing to do with the thing in question; here we will have to strike against something which will occur to you under the pressure of my hand."

The hysterical stream of thought, even if it reaches into the unconscious, may be expected to show the same logical connections and sufficient causations as those that would be formed in a normal individual. A looseness of these relationships does not lie within the sphere of influence of the neurosis. If the association of ideas of neurotics, and especially of hysterics, makes a different impression, if the relation of the intensities of different ideas does not seem to be explainable here on psychological determinants alone, we know that such manifestations are due to the existence of concealed unconscious motives. Such secret motives may be expected wherever such a deviation in the connection, or a transgression from the normally justified causations can be demonstrated.

To be sure one must free himself from the theoretical prejudice that one has to deal with abnormal brains of dégénerés and deséquilibrés, in whom the freedom of overthrowing the common psychological laws of the association of ideas is a stigma, or in whom a preferred idea without any motive may grow intensively excessive, and another without psychological motives may remain indestructible. Experience shows the contrary in hysteria; as soon as the hidden—often unconsciously remaining—motives have been revealed and brought to account there remains nothing in the hysterical thought connection that is enigmatical and anomalous.

Thus by tracing the breaches in the first statements of the patient, which are often hidden by "false connections," one gets hold of a part of the logical thread at the periphery, and thereafter continues the route by the pressure procedure.

Very seldom do we succeed in working our way into the inner

strata by the same thread, usually it breaks on the way when the pressure fails, giving up either no experience, or one which cannot be explained or be continued despite all efforts. In such a case we soon learn how to protect ourselves from the obvious confusion. The expression of the patient must decide whether one really reached an end or encountered a case needing no psychic explanation, or whether it is the enormous resistance that halts the work. If the latter cannot soon be overcome, it may be assumed that the thread has been followed into a stratum which is as yet impenetrable. One lets it fall in order to grasp another thread which may, perhaps, be followed up just as far. If one has followed all the threads into this stratum, if the knottings have been reached through which no single isolated thread can be followed, it is well to think of seizing anew the resistances on hand.

One can readily imagine how complicated such a work may become. By constantly overcoming the resistance, one pushes his way into the inner strata, gaining knowledge concerning the accumulative themes and passing threads found in this layer; one examines as far as he can advance with the means at hand, and by means of the pressure procedure he gains first information concerning the content of the next stratum.

The threads are dropped, taken up again, and followed until they reach the juncture; they are always retrieved, and by following a memory fascicle one reaches some by-way which finally opens again. In this manner it is possible to leave the work, layer by layer, and advance directly on the main road to the nucleus of the pathogenic organization. Thus the fight is won but not finished. One has to follow up the other threads and exhaust the material; but now the patient helps again energetically, for his resistance has mostly been broken.

In these later stages of the work it is of advantage if one can surmise the connection and tell it to the patient before it has been revealed. If the conjecture is correct the course of the analysis is accelerated, but even an incorrect hypothesis helps, for it urges the patient to participate and elicits from him energetic refutation, thus revealing that he surely knows better.

One, thereby, becomes astonishingly convinced, *that it is not possible to press upon the patient things which he apparently does not know, or to influence the results of the analysis by exciting*

his expectations. I have not succeeded a single time in altering or falsifying the reproductions of memory or the connections of events by my predictions; had I succeeded it surely would have been revealed in the end by a contradiction in the construction. If anything occurred as I predicted, the correctness of my conjecture was always attested by numerous trustworthy reminiscences. Hence, one must not fear to express his opinion to the patient concerning the connections which are to follow; it does no harm.

Another manifestation which can be repeatedly observed refers to the patient's independent reproductions. It can be asserted that not a single reminiscence comes to the surface during such an analysis which has no significance. An interposition of irrelevant memory pictures having no connection with the important associations does not really occur. An exception not contrary to the rule may be postulated for those reminiscences which, though in themselves unimportant, are indispensable as intercalations, since the associations between two related reminiscences passed through them only.—As mentioned above, the period during which a reminiscence abides in the pass of the patient's consciousness is directly proportionate to its significance. A picture which does not disappear requires further consideration; a thought which cannot be abolished must be followed further. A reminiscence never recurs if it has been adjusted, a picture spoken away cannot be seen again. However, if that does happen it can be definitely expected that the second time the picture will be joined by a new content of thought, that the idea will contain a new inference which will show that no perfect adjustment has taken place. On the other hand, a recurrence of different intensities, at first vaguely then quite plainly, often occurs, but it does not, however, contradict the assertion just advanced.

If the object of the analysis is to remove a symptom (pains, symptoms like vomiting, sensations and contractures) which is capable of aggravation or recurrence, the symptom shows during the work the interesting and not undesirable phenomenon of "joining in the discussion." The symptom in question reappears, or appears with greater intensity, as soon as one penetrates into the region of the pathogenic organization containing the etiology of this symptom, and it continues to accompany the work with

characteristic and instructive fluctuations. The intensity of the same (let us say of a nausea) increases the deeper one penetrates into its pathogenic reminiscence; it reaches its height shortly before the latter has been expressed, and suddenly subsides or disappears completely for a while after it has been fully expressed. If through resistance the patient delays the expression, the tension of the sensation of nausea becomes unbearable, and, if the expression cannot be forced, vomiting actually sets in. One thus gains a plastic impression of the fact that the vomiting takes the place of a psychic action (here that of speaking) just as was asserted in the conversion theory of hysteria.

The fluctuations of intensity on the part of the hysterical symptom recurs as often as one of its new and pathogenic reminiscences is attacked; the symptom remains, as it were, all the time the order of the day. If it is necessary to drop for a while the thread upon which this symptom hangs, the symptom, too, merges into obscurity in order to emerge again at a later period of the analysis. This play continues until, through the completion of the pathogenic material, there occurs a definite adjustment of this symptom.

Strictly speaking the hysterical symptom does not behave here differently than a memory picture or a reproduced thought which is evoked by the pressure of the hand. Here, as there, the adjustment necessitates the same obsessing obstinacy of recurrence in the memory of the patient. The difference lies only in the apparent spontaneous appearance of the hysterical symptom, whereas one readily recalls having himself provoked the scenes and ideas. But in reality the memory symbols run in an uninterrupted series from the unchanged memory remnants of affectful experiences and thinking-acts to the hysterical symptoms.

The phenomenon of "joining in the discussion" of the hysterical symptom during the analysis carries with it a practical inconvenience to which the patient should be reconciled. It is quite impossible to undertake the analysis of a symptom in one stretch or to divide the pauses in the work in such a manner as to precisely coincide with the resting point in the adjustment. Furthermore, the interruption which is categorically dictated by the accessory circumstances of the treatment, like the late hour, etc., often occurs in the most awkward locations, just when some

critical point could be approached or when a new theme comes to light. These are the same inconveniences which every newspaper reader experiences in reading the daily fragments of his newspaper romance, when, immediately after the decisive speech of the heroine, or after the report of a shot, etc., he reads, "To be continued." In our case the raked-up but unabolished theme, the at first strengthened but not yet explained symptom, remains in the patient's psyche, and troubles him perhaps more than before.

But the patient must understand this as it cannot be differently arranged. Indeed, there are patients who during such an analysis are unable to get rid of the theme once touched; they are obsessed by it even during the interval between the two treatments, and as they are unable to advance alone with the adjustment, they suffer more than before. Such patients, too, finally learn to wait for the doctor, postponing all interest which they have in the adjustment of the pathogenic material for the hours of the treatment, and they then begin to feel freer during the intervals.

The general condition of the patient during such an analysis seems also worthy of consideration. For a while it remains uninfluenced by the treatment expressing the former effective factors. But then a moment comes in which the patient is seized, and his interest chained and from that time his general condition becomes more and more dependent on the condition of the work. Whenever a new explanation is gained and an important contribution in the chain of the analysis is reached, the patient feels relieved and experiences a presentiment of the approaching deliverance; but at each standstill of the work, at each threatening entanglement, the psychic burden which oppresses him grows, and the unhappy sensation of his incapacity increases. To be sure, both conditions are only temporary, for the analysis continues disdaining to boast of a moment of wellbeing, and continues regardlessly over the period of gloominess. One is generally pleased if it is possible to substitute the spontaneous fluctuations in the condition of the patient by such as one himself provokes and understands, just as one prefers to see in place of the spontaneous discharge of the symptoms that order of the day which corresponds to the condition of the analysis.

Usually the deeper one penetrates into the above described layers of the psychic structure the more obscure and difficult the work will at first become. But once the nucleus is reached light ensues, and there is no more fear that a marked gloom will be cast over the condition of the patient. However, the reward of the labor, the cessation of symptoms of the disease can only be expected when the full analysis of every individual symptom has been accomplished; indeed where the individual symptoms are connected through many junctures one is not even encouraged by partial successes during the work. By virtue of the great number of existing causal connections every unadjusted pathogenic idea acts as a motive for the complete creation of the neurosis, and only with the last word of the analysis does the whole picture of the disease disappear, just as happens in the behavior of the individual reproduced reminiscence.

If a pathogenic reminiscence or a pathogenic connection which was previously withdrawn from the ego-consciousness is revealed by the work of the analysis and inserted into the ego, one can observe in the psychic personality which was thus enriched the many ways in which it gave utterance to its gain. Especially does it frequently happen that after the patients have been painstakingly forced to a certain knowledge, they say: "Why I have known that all the time, I could have told you that before." Those who have more insight recognize this afterwards as a self deception and accuse themselves of ungratefulness. In general the position that the ego takes towards the new acquisition depends upon the strata of the analysis from which the latter originates. Whatever belongs to the outermost layers is recognized without any difficulty, for it always remained in the possession of the ego, and the only thing that was new to the ego was its connection with the deeper layers of the pathogenic material. Whatever is brought to light from these deeper layers also finds appreciation and recognition, but frequently only after long hesitation and reflection. Of course, visual memory pictures are here more difficult to deny than reminiscences of mere streams of thought. Not very seldom the patient will at first say, "it is possible that I thought of that, but I cannot recall it," and only after a longer familiarity with this supposition recognition will appear. He then recalls and even verifies by sight

associations that he once really had this thought. During the analysis I make it a point of holding the value of an emerging reminiscence independent of the patient's recognition. I am not tired of repeating that we are obliged to accept everything that we bring to light with our means. Should there be anything unreal or incorrect in the material thus revealed, the connection will later teach us to separate it. I may add that I rarely ever have occasion to subsequently withdraw the recognition from a reminiscence which I had preliminarily admitted. In spite of the deceptive appearance of an urgent contradiction, whatever came to the surface finally proved itself correct.

Those ideas which originate in the deepest layer, and from the nucleus of the pathogenic organization, are only with the greatest difficulty recognized by the patient as reminiscences. Even after everything is accomplished, when the patients are overcome by the logical force and are convinced of the curative effect accompanying the emerging of this idea—I say even if the patients themselves assume that they have thought "so" and "so" they often add, "but to recall, that I have thought so, I cannot." One readily comes to an understanding with them by saying that these were unconscious thoughts. But how should we note this state of affairs in our own psychological views? Should we pay no heed to the patient's demurring recognition which has no motive after the work has been completed; should we assume that it was really a question of thoughts which never occurred, and for which there is only a possibility of existence so that the therapy would consist in the consummation of a psychic act which at that time never took place? It is obviously impossible to state anything about it, that is, to state anything concerning the condition of the pathogenic material previous to the analysis, before one has thoroughly explained his psychological views especially concerning the essence of consciousness. It is a fact worthy of reflection that in such analyses one can follow a stream of thought from the conscious into the unconscious (that is, absolutely not recognized as a reminiscence) thence draw it for some distance through the consciousness, and again see it end in the unconscious; and still this variation of the psychic elucidation would change nothing in it, in its logicalness, and in a single part of its connection. Should I then have this stream of thought freely before me, I could not

conjecture what part was, and what part was not recognized by the patient as a reminiscence. In a measure I see only the points of the stream of thought merging into the unconscious, just the reverse of that which has been claimed for our normal psychic processes.

I still have another theme to treat which plays an undesirably great part in the work of such a cathartic analysis. I have already admitted the possibility that the pressure procedure may fail and despite all assurance and urging it may evoke no reminiscences. I also stated that two possibilities are to be considered, there is really nothing to evoke in the place where we investigate—that can be recognized by the perfectly calm expression of the patient—or, we have struck against a resistance to be overcome only at some future time. We are confronted with a new layer into which we cannot as yet penetrate, and this can again be read from the drawn and psychic exertion of the patient's expression. A third cause may be possible which also indicates an obstacle, not as to the purport, but externally. This cause occurs when the relation of the patient to the physician is disturbed, and signifies the worst obstacle that can be encountered. One may consider that in every more serious analysis.

I have already alluded to the important rôle falling to the personality of the physician in the creation of motives which are to overcome the psychic force of the resistance. In not a few cases, especially in women and where we deal with the explanation of erotic streams of thought, the cooperation of the patient becomes a personal sacrifice which must be recompensed by some kind of a substitute of love. The great effort and the patient friendliness for the physician suffice as such substitutes. If this relation of the patient to the physician is disturbed the readiness of the patient fails; if the physician desires information concerning the next pathogenic idea, the patient is confronted by the consciousness of the unpleasantness which has accumulated in her against the physician. As far as I have discovered this obstacle occurs in three principal cases:

1. In personal estrangement, if the patient believes herself slighted, disparaged and insulted, or if she hears unfavorable accounts concerning the physician and his methods of treatment.

This is the least serious case. The obstacle can readily be overcome by discussion and explanation, although the sensitiveness and the suspicion of hysterics can occasionally manifest itself in unsuspected dimensions.

2. If the patient is seized with the fear that she becomes too accustomed to her physician, that in his presence she loses her independence and could even become sexually dependent upon him; this case is more significant because it is less determined individually. The occasion for this obstacle lies in the nature of the therapeutic distress. The patient has now a new motive to resist which manifests itself, not only in a certain reminiscence but at each attempt of the treatment. Whenever the pressure procedure is started the patient usually complains of headache. Her new motive for the resistance remains to her for the most part unconscious, and she manifests it by a newly created hysterical symptom. The headache signifies the aversion towards being influenced.

3. If the patient fears lest the painful ideas emerging from the content of the analysis would be transferred to the physician. This happens frequently, and, indeed, in many analyses it is a regular occurrence. The transference to the physician occurs through false connections.[9] I must here give an example. The origin of a certain hysterical symptom in one of my hysterical patients was the wish she entertained years ago which was immediately banished into the unconscious, that the man with whom she at that time conversed would heartily grasp her and force a kiss on her. After the ending of a session such a wish occurred to the patient in reference to me. She was horrified and spent a sleepless night, and at the next session, although she did not refuse the treatment she was totally unfit for the work. After I had discovered the obstacle and removed it, the work continued. The wish that so frightened the patient appeared as the next pathogenic reminiscence, that is, as the one now required by the logical connection. It came about in the following manner: The content of the wish at first appeared in the patient's consciousness without the recollection of the accessory circumstances which would have transferred this wish into the past. By the

[9] See Breuer und Freud, Studien über Hysterie. Deuticke, Leipzig und Wien, 1895, p. 55.

associative force prevailing in consciousness the existing wish became connected with my own person, with which the patient could naturally occupy herself, and in this mesalliance—which I call a false connection—the same affect became reawakened which originally urged the patient to banish this clandestine wish. As soon as I discovered this I could presuppose every similar claim on my personality to be another transference and false connection. It is remarkable how the patient falls a victim to deception on every new occasion.

No analysis can be brought to an end if one does not know how to meet the resistances resulting from the causes mentioned. The way can be found if one bears in mind that the new symptom produced after the old model should be treated like the old symptoms. In the first place it is necessary to make the patient conscious of the obstacle. In one of my patients, in whom the pressure symptoms suddenly failed and I had cause to assume an unconscious idea like the one mentioned in 2, I met it for the first time with an unexpected attack. I told her that there must have originated some obstacle against the continuation of the treatment and that the pressure procedure has at least the power to show her the obstacle, and then pressed her head. She then said, surprisingly, "I see you sitting here on the chair, but that is nonsense, what can that mean?"—But now I could explain it.

In another patient the obstacle did not usually show itself directly on pressure, but I could always demonstrate it by taking the patient back to the moment in which it originated. The pressure procedure never failed to bring back this moment. By discovering and demonstrating the obstacle, the first difficulty was removed, but a greater one still remained. The difficulty lay in inducing the patient to give information where there was an obvious personal relation and where the third person coincided with the physician. At first I was very much annoyed about the increase of this psychic work until I had learned to see the lawful part of this whole process, and I then also noticed that such a transference does not cause any considerable increase in the work. The work of the patient remained the same, she perhaps had to overcome the painful affect of having entertained such a wish, and it seemed to be the same for the success whether she took this psychic repulsion as a theme of the work in the historical

case or in the recent case with me. The patients also gradually learned to see that in such transferences to the person of the physician they generally dealt with a force or a deception which disappeared when the analysis was accomplished. I believe, however, that if I should have delayed in making clear to them the nature of the obstacle, I would have given them a new, though a milder, hysterical symptom for another spontaneously developed.

I now believe that I have sufficiently indicated how such analyses should be executed, and the experiences connected with them. They perhaps make some things appear more complicated than they are, for many things really result by themselves during such work. I have not enumerated the difficulties of the work in order to give the impression that in view of such requirements it pays for the physician and patient to undertake a cathartic analysis only in the rarest cases. I allow my medical activities to be inflected by the contrary suppositions.—To be sure I am unable to formulate the most definite indications for the application of the here discussed therapeutic method without entering into the valuation of the more significant and more comprehensive theme of the therapy of the neuroses in general. I have often compared the cathartic psychotherapy to surgical measures, and designated my cures as psychotherapeutic operations; the analogies follow the opening of a pus pocket, the curetting of a carious location, etc. Such an analogy finds its justification, not so much in the removal of the morbid as in the production of better curative conditions for the issue of the process.

When I promised my patients help and relief through the cathartic method, I was often obliged to hear the following objections: "You say, yourself, that my suffering has probably to do with my own relation and destinies. You cannot change any of that. In what manner, then, can you help me?" To this I could always answer: "I do not doubt at all that it would be easier for destiny than for me to remove your sufferings, but you will be convinced that much will be gained if we succeed in transforming your hysterical misery into everyday unhappiness, against which you will be better able to defend yourself with a restored nervous system."

CHAPTER V.

THE DEFENSE NEURO-PSYCHOSES.

A TENTATIVE PSYCHOLOGICAL THEORY OF ACQUIRED HYSTERIA, MANY PHOBIAS AND OBSESSIONS, AND CERTAIN HALLUCINATORY PSYCHOSES.

After an exhaustive study of many nervous patients afflicted with phobias and obsessions a tentative explanation of these symptoms urged itself upon me. This helped me afterwards happily to divine the origin of such morbid ideas in new and other cases, and I therefore believe it worthy of reporting and further examination. Simultaneously with this "psychological theory of phobias and obsessions," the examination of these patients resulted in a contribution to the theory of hysteria, or rather in an alteration of the same, which seems to imply an important and common character to hysteria as well as the mentioned neuroses. Furthermore I had the opportunity to look into the psychological mechanism of a form of indubitable psychic disease and found that my attempted observation shows an intelligible connection between these psychoses and the two neuroses mentioned. At the conclusion of this theme I will describe the supporting hypothesis which I have used in all three cases.

I.

I am beginning with that alteration which seems to be necessary for the theory of the hysterical neuroses.

That the symptom-complex of hysteria as far as it can be understood justifies the assumption of a splitting of consciousness with the formation of separate psychic groups, has attained general recognition since P. Janet, J. Breuer, and others have given out their interesting work. Less understood are the opinions concerning the origin of this splitting of consciousness and concerning the rôle played by this character in the structure of the hysterical neuroses.

According to Janet's[1] theory, the splitting of consciousness is a

[1] État mental des hystériques, Paris, 1893 and 1894. Quelques définitions récentes de l'hystérie, Arch. de Neurol., 1893, XXXV–VI.

primary feature of the hysterical alteration. It is due to a congenital weakness of the capacity for psychic synthesis, and to a narrowing of the "field of consciousness" (champ du conscience) which as a psychic stigma proves the degeneration of hysterical individuals.

In contradistinction to Janet's views, which in my opinion admit the most manifold objections, are those advocated by J. Breuer in our joint communication. According to Breuer, the "basis and determination" of hysteria is the occurrence of peculiar dream-like conscious states with a narrowed association capacity, for which he proposes the name "hypnoid states." The splitting of consciousness is secondary and acquired, and originates because the ideas emerging in the hypnoid states are isolated from associative communication with the rest of consciousness.

I can now demonstrate two other extreme forms of hysteria in which it is impossible to show that the splitting of consciousness is primary in the sense of Janet. In the first of these forms I could repeatedly show that the splitting of the content of consciousness was an arbitrary act of the patient, that is, it was initiated through an exertion of the will which motive can be stated. I naturally do not maintain that the patient intended to produce a splitting of his consciousness; the patient's intention was different, but instead of attaining its aim it provoked a splitting of consciousness.

In the third form of hysteria, as we have demonstrated by psychic-analysis of intelligent patients, the splitting of consciousness plays only an insignificant and perhaps really no rôle. This includes those cases in which there had been no reaction to the traumatic stimulus and which were then adjusted and cured by abreaction. They are the pure retention hysterias.

In connection with the phobias and obsessions I have only to deal here with the second form of hysteria which for reasons to be presently explained I will designate as defense hysteria and thus distinguish it from the hypnoid and retention hysterias. Preliminarily I am able to call my cases of defense hysteria "acquired" hysterias for they show neither marked hereditary taints nor any degenerative disfigurements.

In those patients whom I have analyzed there existed psychic health until the moment in which a case of incompatibility oc-

curred in their ideation, that is, until there appeared an experience, idea, or feeling which evoked such a painful affect that the person decided to forget it because he did not trust his own ability to remove the resistance between the unbearable ideas and his ego.

Such incompatible ideas originate in the feminine sex on the basis of sexual experiences and feelings. With all desired precision the patients recall their efforts of defense, their intention "to push it away," not to think of it, to repress it. As appropriate examples I can easily cite the following cases from my own experience: A young lady reproached herself because, while nursing her sick father, she thought of a young man who made a slight erotic impression on her; a governess fell in love with her employer and decided to crowd it out of her mind because it was incompatible with her pride, etc.

I am unable to maintain that the exertion of the will, in crowding such thoughts out of one's mind, is a pathological act, nor am I able to state whether and how, the intentional forgetting succeeds in these persons who remain well under the same psychic influences. I only know that in the patients whom I analyzed such "forgetting" was unsuccessful and led to either a hysteria, obsession, or a hallucinatory psychosis. The ability to produce, by the exertion of the will one of these states all of which are connected with the splitting of consciousness, is to be considered as the expression of a pathological disposition, but it need not necessarily be identified with personal or hereditary "degeneration."

Over the road leading from the patient's exertion of the will to the origin of a neurotic symptom I formed a conception which in the current psychological abstractions may be thus expressed: The task assumed by the defensive ego to treat the incompatible idea as "non arrivée" can not be directly accomplished. The memory trace as well as the affect adhering to the idea are here and can not be exterminated. The task can however, be brought to an approximate solution if it is possible to change the strong idea into a weak one and to take away the affect or sum of excitement which adheres to it. The weak idea will then exert almost no claims on the association work; but the separated sum of excitement must be utilized in another direction.

Thus far the processes are the same in hysteria, in phobias and

obsessions, but from now on their ways part. The unbearable idea in hysteria is rendered harmless because the sum of excitement is transformed into physical manifestations, a process for which I would like to propose the term conversion.

The conversion may be total or partial, and follows that motor or sensory innervation which is either ultimately or more loosely connected with the traumatic experience. In this way the ego succeeds in freeing itself from opposition but instead it becomes burdened with a memory symbol which remains in consciousness as an unadjusted motor innervation, or as a constantly recurring hallucinatory sensation similar to a parasite. It thus remains fixed until a conversion takes place in the opposite direction. The memory symbol of the repressed idea does not perish, but from now on forms the nucleus for a second psychic group.

I will follow up this view of the psycho-physical processes in hysteria with a few more words. If such a nucleus for an hysterical splitting is once formed in a "traumatic moment" it then increases in other moments which might be designated as "auxiliary traumatic" as soon as a newly formed similar impression succeeds in breaking through the barrier formed by the will and in adding new affects to the weakened idea, and in forcing for a while the associative union of both psychic groups until a new conversion produces defense. The condition thus attained in hysteria in regard to the distribution of the excitement, proves to be unstable in most cases. As shown by the familiar contrast of the attacks and the persistent symptoms, the excitement which was pushed on a false path (in the bodily innervation) now and then returns to the idea from which it was discharged and forces the person to associative elaboration or to adjustment in hysterical attacks. The effect of Breuer's cathartic method consists in the fact that it consciously reconducts the excitement from the physical into the psychic spheres and then forces an adjustment of the contradiction through intellectual work, and a discharge of the excitement through speech.

If the splitting of consciousness in acquired hysteria is due to an act of volition we can explain with surprising simplicity the remarkable fact that hypnosis regularly broadens the narrowed consciousness of hysteria, and causes the split off psychic groups to become accessible. For we know that it is peculiar to all

sleep-like states to remove that distribution of excitement which depends on the " will " of the conscious personality.

We accordingly recognize that the characteristic moment of hysteria is not the splitting of consciousness but the ability of conversion and as an important part of the hitherto unknown disposition of hysteria we can mention the psycho-physical adaptation for the transference of a great sum of excitement into bodily innervation.

The adaptation does not in itself exclude psychic health, and leads to hysteria only in event of a psychic incompatibility or accumulation of excitement. With this turn, we—Breuer and I—come near to the familiar definitions of hysteria of Oppenheim[2] and Strumpel,[3] and deviate from Janet,[4] who assigns to the splitting of consciousness too great a rôle in the characteristics of hysteria. The description here given can lay claim to the fact that it explains the connection between the conversion and the hysterical splitting of consciousness.

II.

In a predisposed person if there is no adaptation for conversion and still for the purpose of defense a separation of the unbearable idea from its affect is undertaken, the affect must then remain in the psychic sphere. The weakened idea remains apart from all association in consciousness, but its freed affect attaches itself to other not in themselves unbearable ideas, which on account of this " false " connection become obsessions. This is in brief the psychological theory of the obsessions and phobias concerning which I have spoken above.

[2] Oppenheim: Hysteria is an exaggerated expression of emotion. But the "expression of emotion" represents that amount of psychic excitement which normally experiences conversion.

[3] Strümpel: The disturbance of hysteria lies in the psycho-physical, there where the physical and psychical are connected with each other.

[4] Janet, in the second chapter of his spirited essay "Quelques definitions," etc., has treated the objection that the splitting of consciousness belongs also to the psychoses and the so called psychaesthenia, but in my opinion he has not satisfactorily solved it. It is essentially this objection which urged him to call hysteria a form of degeneration. But through no characteristic is he able to separate sufficiently the hysterical splitting of consciousness from the psychopathic, etc.

I will now state what parts demanded in this theory can be directly demonstrated and what parts I have supplemented. Besides the end product of the process, the obsession, we can in the first place directly demonstrate the source from which the affect in the false connection originates. In all cases that I have analyzed it was the sexual life that has furnished a painful affect of precisely the same character as the one attached to the obsession. It is not theoretically excluded that this affect could not occasionally originate in other spheres, but I must say that thus far I have found no other origin. Moreover, one can readily understand that it is precisely the sexual life which furnishes the most manifold occasions for the appearance of unbearable ideas.

Moreover, the exertion of the will, the attempt at defence, upon which this theory lays stress is demonstated by the most unequivocal utterances of the patients. At least in a number of cases the patients themselves inform us that the phobia or obsession appeared only after the exertion of the will manifestly gained its point. "Something very disagreeable happened to me once and I have exerted all my power to push it away, not to think of it. When I have finally succeeded I have gotten the other thing instead, which I have not lost since." With these words a patient verified the main points of the theory here developed.

Not all who suffer from obsessions are so clear concerning the origin of the same. As a rule when we call the patient's attention to the original idea of a sexual nature we receive the following answer: "It could not have come from that. Why I have not thought much about it. For a moment I was frightened, then I distracted myself and since then it has not bothered me." In this, so frequent objection, we have the proof that the obsession represents a compensation or substitute for the unbearable sexual idea, and that it has taken its place in consciousness.

Between the patient's exertion of the will which succeeds in repressing the unacceptable sexual idea and the appearance of the obsession, which though in itself of little intensity, is here furnished with inconceivably strong affect, there is a yawning gap which the theory here developed will fill. The separation of the sexual idea from its affect and the connection of the latter with another suitable but not unbearable idea—these are processes which take place unconsciously which we can only presume but not

prove by any clinico-psychological analysis. Perhaps it would be more correct to say that these are not really processes of a psychic nature but physical processes of which the psychic result so presents itself that the expressions "separation of the idea from its affect and false connection of the latter," seem actual occurrences.

Besides the cases evincing in turn the sexual unbearable idea and the obsession we find a series of others in which there are simultaneously obsessions and painfully occentuated sexual ideas. It will not do very well to call the latter "sexual obsessions"; they lack the essential character of obsessions in proving themselves fully justified, whereas the painfulness of the ordinary obsession is a problem for the doctor as well as the patient. From the amount of insight that could be obtained in such cases, it seems that we deal here with a continued defense against sexual ideas which are constantly renewed, a work heretofore not accomplished.

As long as the patients are aware of the sexual origin of their obsessions they often conceal them. If they complain they generally express surprise that this affect underlies the symptoms, at being afraid, and at having certain impulses, etc. To the experienced physician, however, the affect appears justified and intelligible; he finds the striking part only in the connection of such an affect with an idea unworthy of it. In other words the affect of the obsession appears to him as one dislocated or transposed, and if he has accepted the observations here laid down he can in a great many cases of obsessions attempt a retranslation into the sexual.

Any idea which either through its character may be combinable with an affect of such quality or which bears a certain relation to the unbearable by virtue of which it seems fit as a substitute for the same, may be used for the secondary connection of the freed affect. Thus, for example, freed anxiety, the sexual origin of which can not be recalled, attaches itself to the common primary phobias of man for animals, thunderstorms, darkness, etc., or to things which are unmistakably in some way associated with the sexual, such as urination, defecation, pollutions and infections.

The advantage gained by the ego in the transposition of the affect for the purpose of defense is considerably less than in the hysterical conversion of psychic excitement into somatic innerva-

tion. The affect under which the ego has suffered remains now as ever unchanged and undiminished, but the unbearable idea is suppressed and excluded from memory. The repressed ideas again form the nucleus of a second psychic group which I believe can be accessible without having recourse to hypnotism. That in the phobias and obsessions there appear none of the striking symptoms which in hysteria accompany the formation of an independent psychic group, is due to the fact that in the former case the whole transformation remains in the psychic sphere and the somatic innervation experiences no change.

What I have here said concerning obsessions I will explain by some examples which are probably of a typical nature:

1. A young girl suffers from obsessive reproaches. If she reads anything in the journal about false coiners she conceives the thought that she too, made counterfeit money; if a murder was anywhere committed by an unknown assassin she anxiously asked herself whether she had not committed this crime. At the same time she is perfectly aware of the absurdity of these obsessive reproaches. For a time the consciousness of her guilt gained such a power over her that her judgment was suppressed, and she accused herself before her relatives and physician of having really committed all these crimes (Psychosis through simple aggravation—overwhelming psychosis—Überwältigungspsychose). A thorough examination revealed the source of the origin of this guilty conscience. Accidentally incited by a sensual feeling she allowed herself to be allured by a friend to masturbate. She practiced it for years with the full consciousness of her wrong doing, and under the most violent but useless self-reproaches.—The girl was cured after a few months' treatment and strict watching.

2. Another girl suffered from the fear of getting sudden desires of micturition and of being forced to wet herself. This began after such a desire had really forced her to leave a concert hall during the performance. This phobia had gradually caused her to become quite incapable of any enjoyment and social relationship. She felt secure only when she knew that there was a toilet in the neighborhood to which she could repair unobserved. An organic suffering which might have justified this lack of confidence of the control of the bladder was excluded. At home among quiet surroundings and during the night there was no such

desire to micturate. Detailed examination showed that the desire to micturate appeared for the first time under the following conditions: A gentleman to whom she was not indifferent took a seat in the concert hall not far from her. She began to think and to picture to herself how she would sit near him as his wife. In this erotic revery she experienced that physical feeling which must be compared to erection in the man, and which in her—I do not know whether it is general—ended in a slight desire to micturate. She now became extremely frightened over her otherwise accustomed sexual sensation because she had determined to overcome this as well as every desire, and in the next moment the affect transposed itself to the accompanying desire to micturate and forced her to leave the hall after a very painful struggle. In her life she was so prudish that she experienced an intensive horror for all things sexual, and could not conceive the thought of ever marrying; on the other hand she was sexually so hyperesthetic that during every erotic revery, which she gladly allowed herself, there appeared sensual feeling. The erection was always accompanied by the desire to micturate, and up to the time of the scene in the concert hall it had made no impression on her. The treatment led to an almost complete control of the phobia.

3. A young woman who had only one child after five years of married life complained of obsessive impulses to throw herself from the window or balcony, and of fears lest at the sight of a sharp knife she might kill her child. She admitted that the marriage relations were seldom practised and then only with caution against conception; but she added that she did not miss this as she was not of a sensual nature. I then ventured to tell her that at the sight of a man she conceives erotic ideas, and that she therefore lost confidence in herself and imagined herself a depraved person fit for anything. The retranslation of the obsession into the sexual was successful; weeping, she soon admitted her long concealed marital misery, and then mentioned painful ideas of an unchanged sexual character such as the often recurring sensation of something forcing itself under her skirts.

I have made use of such experiences in the therapy of phobias and obsessions, and despite the patient's resistances I have redirected the attention to the repressed sexual ideas, and wherever feasible I have blocked the sources from which the same origi-

nated. To be sure I cannot maintain that all phobias and obsessions originate in the manner here revealed; first, my experience, in proportion to the abundance of these neuroses, embraces only a limited amount, and second, I, myself, know that these " psychasthenic " symptoms (according to Janet's designation) are not all of the same value.[5] Thus, for instance, there are pure hysterical phobias. But I believe that the mechanism of the transposition of the affect will be demonstrated in the greater part of the phobias and obsessions, and I must assert that these neuroses, which are found just as often isolated as combined with hysteria and neurasthenia, are not to be thrown together with the ordinary neurasthenia for which fundamental symptom a psychic mechanism is not all to be assumed.

III.

In both cases thus far considered the defense of the unbearable idea was brought about by the separation of the same from its affect; the idea though weakened and isolated remained in consciousness. There exists, however, a far more energetic and more successful form of defense wherein the ego misplaces the unbearable idea with its affect, and behaves as though the unbearable idea had never approached the ego. But at the moment when this is brought about the person suffers from a psychosis which can only be classified as an " hallucinatory confusion." A single example will explain this assertion. A young girl gives her first impulsive love to a man who she firmly believed reciprocated her love. As a matter of fact she was mistaken; the young man had other motives for visiting her. It was not long before she was disappointed; at first she defended herself against it by converting hysterically the corresponding experience, and thus came to believe that he would come some day to ask her in marriage; but in consequence of the imperfect conversion and the constant pressure of new painful impressions, she felt unhappy and ill. She finally expects him with the greatest tension on a definite day, it is the

[5] The group of typical phobias, for which agoraphobia is a prototype, cannot be reduced to the psychic mechanisms here developed. Furthermore the mechanism of agoraphobia deviates in one decisive point from that of the real obsessions and from phobias based on such. Here there is no repressed idea from which the affect of fear has been separated. The fear of this phobia has another origin.

day of a family reunion. The day passes but he does not come. After all the trains on which he could have come have passed she suddenly merged into an hallucinatory confusion. She thought that he did come, she heard his voice in the garden, and hastened down in her night gown to receive him. For two months after she lived in a happy dream, the content of which was that he was there, that he was always with her, and that everything was as before (before the time of the painfully defended disappointment). The hysteria and depression were thus conquered; during her sickness she never mentioned anything about the last period of doubt and suffering; she was happy as long as she was left undisturbed, and frenzied only when a regulation of her environment prevented her from accomplishing something which she thought quite natural as a result of her blissful dream. This psychosis, unintelligible as it was in its time, was revealed ten years later through hypnotic analysis.

The fact to which I call attention is this: That the content of such an hallucinatory psychosis consists in directly bringing into prominence that idea which was threatened by the motive of the disease. One is therefore justified in saying that through its flight into the psychosis the ego defended the unbearable idea; the process through which this has been brought about withdraws itself from self perception as well as from the psychological-clinical analysis. It is to be considered as the expression of a higher grade of pathological disposition, and can perhaps be explained as follows: The ego tears itself away from the unbearable idea, but as it hangs inseparably together with a part of reality, the ego while accomplishing this performance also detaches itself wholly or partially from reality. The latter is, in my opinion the condition under which hallucinatory vividness is decreed to particular ideas, and hence after very successful defense the person finds himself in a hallucinatory confusion.

I have but very few analyses of such psychoses at my disposal; but I believe that we deal with a very frequently employed type of psychic illness. For analogous examples such as the mother who becoming sick after the loss of her child continues to rock in her arms a piece of wood, or the jilted bride who in full dress expects her bridegroom, can be seen in every insane asylum.

It will perhaps not be superfluous to mention that the three

forms of defense here considered, and hence the three forms of disease to which this defense leads may be united in the same person. The simultaneous occurrence of phobias and hysterical symptoms, so frequently observed in praxis, really belongs to those moments which impede a pure separation of hysteria from other neuroses and urge the formation of the "mixed neuroses." To be sure the hallucinatory confusion is not frequently compatible with the continuation of hysteria and not as a rule with obsessions; but on the other hand it is not rare that a defense psychosis should episodically break through the course of a hysteria or mixed neurosis.

In conclusion I will mention in few words the subsidiary idea of which I have made use in this discussion of the defense neuroses. It is the idea that there is something to distinguish in all psychic functions (amount of affect, sum of excitement), that all qualities have a quantity though we have no means to measure the same—it is something that can be increased, diminished, displaced, and discharged, and that extends over the memory traces of the ideas perhaps like an electric charge over the surface of the body.

This hypothesis, which also underlies our theory of "ab-reaction" ("Preliminary Communication"), can be used in the same sense as the physicist uses the assumption of the current of electric fluid. It is preliminarily justified through its usefulness in the comprehension and elucidation of diverse psychic states.

CHAPTER VI.

On the Right to Separate from Neurasthenia a Definite Symptom-complex as "Anxiety Neurosis."

(Angstneurose.)

It is difficult to assert anything of general validity concerning neurasthenia as long as this term is allowed to express all that for which Beard used it. I believe that neuropathology can only gain by an attempt to separate from the actual neurosis all those neurotic disturbances the symptoms of which are on the one hand more firmly connected among themselves than to the typical neurasthenic symptoms, such as headache, spinal irritation, dyspepsia with flatulence and constipation, and which on the other hand show essential differences from the typical neurasthenic neurosis in their etiology and mechanism. If we accept this plan we will soon gain quite a uniform picture of neurasthenia. We will soon be able to differentiate—sharper than we have hitherto succeeded—from the real neurasthenia the different pseudo-neurasthenias, such as the organically determined nasal reflex neurosis, the neurotic disturbances of cachexias and arterio-sclerosis, the early stages of progressive paralysis, and of some psychoses. Furthermore, following the proposition of Moebius, some status nervosi of hereditary degenerates will be set aside and we will also find reasons for ascribing some of the neuroses which are now called neurasthenia to melancholia, especially those of an intermittent or periodic nature. But we force the way into the most marked changes if we decide to separate from neurasthenia that symptom-complex which I shall hereafter describe and which especially fulfills the conditions formulated above. The symptoms of this complex are clinically more related to one another than to the real neurasthenic symptoms, that is, they frequently appear together and substitute one another in the course of the disease, and both the etiology as well as the mechanism of this neurosis differs basically from the etiology and the

mechanism of the real neurasthenia which remains after such a separation.

I call this symptom-complex "anxiety neurosis" (Angstneurose) because the sum of its components can be grouped around the main symptom of anxiety, because each individual symptom shows a definite relation to anxiety. I believed that I was original in this conception of the symptoms of anxiety neurosis until an interesting lecture by E. Hecker[1] fell into my hands. In this lecture I found the description of the same interpretation with all the desired clearness and completeness. To be sure, Hecker does not separate the equivalents or rudiments of the attack of anxiety from neurasthenia as I intend to do; but this is apparently due to the fact that neither here nor there has he taken into account the diversity of the etiological determinants. With the knowledge of the latter difference every obligation to designate the anxiety neurosis by the same name as the real neurasthenia disappears, for the only object of arbitrary naming is to facilitate the formulation of general assertions.

I. Clinical Symptomatology of Anxiety Neurosis.

What I call "anxiety neurosis" can be observed in complete or rudimentary development, either isolated or in combination with other neuroses. The cases which are in a measure complete, and at the same time isolated, are naturally those which especially corroborate the impression that the anxiety neurosis possesses clinical independence. In other cases we are confronted with the task of selecting and separating from a symptom-complex which corresponds to a "mixed neurosis," all those symptoms which do not belong to neurasthenia, hysteria, etc., but to the anxiety neurosis.

The clinical picture of the anxiety neurosis comprises the following symptoms:

1. *General Irritability.*—This is a frequent nervous symptom, common as such to many nervous states. I mention is here be-

[1] E. Hecker, Über larvierte und abortive Angstzustände bei Neurasthenie, Centralblatt für Nervenheilkunde, December, 1893.—Anxiety is made particularly prominent among the chief symptoms of neurasthenia by Kaan, Der neurasthenische Angstaffekt bei Zwangsvorstellungen und der primordiale Grübelzwang, Wien, 1893.

cause it constantly occurs in the anxiety neurosis and is of theoretical significance. For increased irritability always points to an accumulation of excitement or to an inability to bear accumulation, hence to an absolute or relative accumulation of excitement. The expression of this increased irritability through an auditory hyperesthesia is especially worth mentioning; it is an over sensitiveness for noises, which symptom is certainly to be explained by the congenital intimate relationship between auditory impressions and fright. Auditory hyperesthesia is frequently found as a cause of insomnia, of which more than one form belongs to anxiety neurosis.

2. *Anxious Expectation.*—I can not better explain the condition that I have in mind, than by this name and by some appended examples. A woman, for example, who suffers from anxious expectation thinks of influenza-pneumonia whenever her husband who is afflicted with a catarrhal condition has a coughing spell; and in her mind she sees a passing funeral procession. If on her way home she sees two persons standing together in front of her house she can not refrain from the thought that one of her children fell out of the window; if she hears the bell ring she thinks that someone is bringing her mournful tidings, etc.; yet in none of these cases is there any special reason for exaggerating a mere possibility.

The anxious expectation naturally reflects itself constantly in the normal, and embraces all that is designated as "uneasiness and a tendency to a pessimistic conception of things," but as often as possible it goes beyond such a plausible uneasiness, and it is frequently recognized as a part of constraint even by the patient himself. For one form of anxious expectation, namely, that which refers to one's own health, we can reserve the old name of hypochondria. Hypochondria does not always run parallel with the height of the general anxious expectation; as a preliminary stipulation it requires the existence of paresthesias and annoying somatic sensations. Hyponchondria is thus the form preferred by the genuine neurasthenics whenever they merge into the anxiety neurosis, a thing which frequently happens.

As a further manifestation of anxious expectation we may mention the frequent tendency observed in morally sensitive persons to pangs of conscience, scrupulosity, and pedantry, which

varies as it were, from the normal to its aggravation as doubting mania.

Anxious expectation is the most essential symptom of the neurosis; it also clearly shows a part of its theory. It can perhaps be said that we have here a quantum of freely floating anxiety which controls the choice of ideas by expectation and is forever ready to unite itself with any suitable ideation.

3. This is not the only way in which the anxiousness, usually latent but constantly lurking in consciousness, can manifest itself. On the contrary it can also suddenly break into consciousness without being aroused by the issue of an idea, and thus provoke an attack of anxiety. Such an attack of anxiety consists of either the anxious feeling alone without any associated idea, or of the nearest interpretation of the termination of life, such as the idea of "sudden death" or threatening insanity; or the feeling of anxiety becomes mixed with some paresthesia (similar to the hysterical aura); or finally the anxious feeling may be combined with a disturbance of one or many somatic functions, such as respiration, cardiac activity, the vasomotor innervation, and the glandular activity. From this combination the patient renders especially prominent now this and now the other moment. He complains of "heartspasms," "heavy breathing," "profuse perspiration," "inordinate appetite," etc., and in his description the feeling of anxiety is put to the background or it is rather vaguely described as "feeling badly," "uncomfortably," etc.

4. What is interesting and of diagnostic significance is the fact that the amount of admixture of these elements in the attack of anxiety varies extraordinarily, and that almost any accompanying symptom can alone constitute the attack as well as the anxiety itself. Accordingly there are rudimentary attacks of anxiety, and equivalents for the attack of anxiety, probably all of equal significance in showing a profuse and hitherto little appreciated richness in forms. A more thorough study of these larvated states of anxiety (Hecker) and their diagnostic division from other attacks ought soon to become the necessary work for the neuropathologist.

I now add a list of those forms of attacks of anxiety with which I am acquainted. There are attacks:

(*a*) With disturbances of heart action, such as palpitation with

transitory arrythmia, with longer continued tachycardia up to grave states of heart weakness, the differentiation of which from organic heart affection is not always easy; among such we have the pseudo-angina pectoris, a delicate diagnostic sphere!

(*b*) With disturbances of respiration, many forms of nervous dyspnoea, asthma-like attacks, etc. I assert that even these attacks are not always accompanied by conscious anxiety;

(*c*) Of profuse perspiration, often nocturnal;

(*d*) Of trembling and shaking which may readily be mistaken for hysterical attacks;

(*e*) Of inordinate appetite, often combined with dizziness;

(*f*) Of attack-like appearing diarrhoea;

(*g*) Of locomotor dizziness;

(*h*) Of so called congestions, embracing all that was called vasomotor neurasthenia; and,

(*i*) Of paresthesias (these are seldom without anxiety or a similar discomfort).

5. Very frequently the nocturnal frights (pavor nocturnus of adults) usually combined with anxiety, dyspnea, perspiration, etc., is nothing other than a variety of the attack of anxiety. This disturbance determines a second form of insomnia in the sphere of the anxiety neurosis. Moreover I became convinced that even the pavor nocturnus of children evinces a form belonging to the anxiety neurosis. The hysterical tinge and the connection of the fear with the reproduction of appropriate experience or dream, makes the pavor nocturnus of children appear as something peculiar, but it also occurs alone without a dream or a recurring hallucination.

5. "*Vertigo.*"—This in its lightest forms is better designated as "dizziness," assumes a prominent place in the group of symptoms of anxiety neurosis. In its severer forms the "attack of vertigo," with or without fear, belongs to the gravest symptoms of the neurosis. The vertigo of the anxiety neurosis is neither a rotatory dizziness nor is it confined to certain planes or lines like Menier's vertigo. It belongs to the locomotor or coördinating vertigo, like the vertigo in paralysis of the ocular muscles; it consists in a specific feeling of discomfort which is accompanied by sensations of a heaving ground, sinking legs, of the impossibility to continue in an upright position, and at the same

time there is a feeling that the legs are as heavy as lead, they shake, or give way. This vertigo never leads to falling. On the other hand, I would like to state that such an attack of vertigo may also be substituted by a profound attack of syncope. Other fainting-like states in the anxiety neurosis seem to depend on a cardiac collapse.

The vertigo attack is frequently accompanied by the worst kind of anxiety and is often combined with cardiac and respiratory disturbances. Vertigo of elevations, mountains and precipices, can also be frequently observed in anxiety neurosis; moreover, I do not know whether we are still justified in recognizing a vertigo "a stomacho laeso."

7. On the basis of the chronic anxiousness (anxious expectation) on the one hand, and the tendency to vertiginous attacks of anxiety on the other, there develop two groups of typical phobias; the first refers to the general physiological menaces, while the second refers to locomotion. To the first group belong the fear for snakes, thunderstorms, darkness, vermin, etc., as well as the typical moral overscrupulousness, and the forms of doubting-mania. Here the available fear is merely used to strengthen those aversions which are instinctively implanted in every man. But usually a compulsively acting phobia is formed only after a reminiscence is added to an experience in which this fear could manifest itself; as, for example, after the patient has experienced a storm in the open air. To attempt to explain such cases as mere continuations of strong impressions is incorrect. What makes these experiences significant and their reminiscences durable is after all only the fear which could at that time appear and can also appear today. In other words such impressions remain forceful only in persons with "anxious expectations."

The other group contains agoraphobia with all its accessory forms, all of which are characterized by their relation to locomotion. As a determination of the phobia we frequently find a precedent attack of vertigo; I do not think that it can always be postulated. Occasionally, after a first attack of vertigo without fear, we see that though locomotion is always accompanied by the sensation of vertigo, it remains possible without any restrictions, but as soon as fear attaches itself to the attack of vertigo, locomotion fails, under the conditions of being alone, narrow streets, etc.

The relation of these phobias to the phobias of obsessions, which mechanism I discussed above,[2] is as follows: The agreement lies in the fact that here as there, an idea becomes obsessive through its connection with an available affect. The mechanism of transposition of the affect therefore holds true for both kinds of phobias. But in phobias of the anxiety neurosis this affect is (1) a monotonous one, it is always one of anxiety; (2) it does not originate from a repressed idea, and on psychological analysis it proves itself not further reducible, nor can it be attacked through psychotherapy. The mechanism of substitution does not therefore hold true for the phobias of anxiety neurosis.

Both kinds of phobias (or obsessions) often occur side by side, though the atypical phobias which depend on obsessions need not necessarily develop on the basis of anxiety neurosis. A very frequent, ostensibly complicated mechanism appears if the content of an original simple phobia of anxiety neurosis is substituted by another idea, the substitution is then subsequently added to the phobia. The "protective measures" originally employed in combating the phobia are most frequently used as substitutions. Thus, for example, from the effort to provide oneself with counter evidence that one is not crazy, contrary to the assertion of the hypochondriacal phobia, there results a reasoning mania. The hesitations, doubts, and the many repetitions of the folie du doute originate from the justified doubt concerning the certainty of one's own stream of thoughts, for, through the compulsive-like idea one is surely conscious of so obstinate a disturbance, etc. It may therefore be claimed that many syndromes of compulsion neurosis, like folie du doute and similar ones, can clinically, if not notionally be attributed to anxiety neurosis.[3]

8. The digestive functions in anxiety neurosis are subject to very few but characteristic disturbances. Sensations like nausea and sickly feeling are not rare, and the symptom of inordinate appetite alone or with other congestions, may serve as a rudimentary attack of anxiety. As a chronic alteration analogous to the anxious expectations one finds a tendency to diarrhea which has occasioned the queerest diagnostic mistakes. If I am not mistaken it is this diarrhea to which Moebius[4] has recently called

[2] Die Abwehr-Neuropsychosen, Neurol. Centralbl., 1894, Nr. 10 u. 11.

[3] Obsession et phobies, Révue neurologique, 1895.

[4] Moebius, Neuropathologische Beiträge, 1894, 2. Heft.

attention in a small article. I believe, moreover, that Peyer's[5] reflex diarrhea which he attributes to a disease of the prostate is nothing other than the diarrhea of anxiety neurosis. The deceptive reflex relation is due to the fact that the same factors which are active in the origin of such prostatic affections also come into play in the etiology of anxiety neurosis.

The behavior of the gastro-intestinal function in anxiety neurosis shows a sharp contrast to the influence of this same function in neurasthenia. Mixed cases often show the familiar "fluctuations between diarrhea and constipation." The desire to urinate in anxiety neurosis is analogous to the diarrhea.

9. The paresthesias which accompany the attack of vertigo or anxiety are interesting because they associate themselves into a firm sequence, similar to the sensations of the hysterical aura. But in contrast to the hysterical aura I find these associated sensations atypical and changeable. Another similarity to hysteria is shown by the fact that in anxiety neurosis a kind of conversion[6] into bodily sensations, as, for example, into rheumatic muscles, takes place which otherwise can be overlooked at one's pleasure. A large number of so called rheumatics, who are moreover demonstrable as such, really suffer from an anxiety neurosis. Besides this aggravation of the sensation of pain I have observed in a number of cases of anxiety neurosis a tendency towards hallucinations which could not be explained as hysterical.

10. Many of the so called symptoms which accompany or substitute the attack of anxiety also appear in a chronic manner. They are then still less discernible, for the anxious feeling accompanying them appears more indistinct than in the attack of anxiety. This especially holds true for the diarrhea, vertigo, and paresthesias. Just as the attack of vertigo can be substituted by an attack of syncope, so can the chronic vertigo be substituted by the continuous feeling of feebleness, lassitude, etc.

II. The Occurrence and Etiology of Anxiety Neurosis.

In some cases of anxiety neurosis no etiology can readily be ascertained. It is noteworthy that in such cases it is seldom difficult to demonstrate a marked hereditary taint.

[5] Peyer, Die nervösen Affektionen des Darmes, Wiener Klinik, Jänner, 1893.

[6] Freud, Abwehr-Neuropsychosen.

Where we have reason to assume that the neurosis is acquired we can find by careful and laborious examination that the etiologically effective moments are based on a series of injuries and influences from the sexual life. These at first appear to be of a varied nature but easily display the common character which explains their homogeneous effect on the nervous system. They are found either alone or with other banal injuries to which a reinforcing effect can be attributed. This sexual etiology of anxiety neurosis can be demonstrated so preponderately often that I venture for the purpose of this brief communication to set aside all cases of a doubtful or different etiology.

For the more precise description of the etiological determinations under which anxiety neurosis occurs, it will be advisable to treat separately those occurring in men and those occurring in women. Anxiety neurosis appears in women—disregarding their predisposition—in the following cases:

(*a*) As virginal fear or anxiety in adults. A number of unequivocal observations showed me that an anxiety neurosis, which is almost typically combined with hysteria, can be evoked in maturing girls, at the first encounter with the sexual problem, that is, at the sudden revelation of the things hitherto veiled, by either seeing the sexual act, or by hearing or reading something of that nature;

(*b*) As fear in the newly married. Young women who remain anesthetic during the first cohabitation not seldom merge into an anxiety neurosis which disappears after the anesthesia is displaced by the normal sensation. As most young women remain undisturbed through such a beginning anesthesia, the production of this fear requires determinants which I will mention;

(*c*) As fear in women whose husbands suffer from ejaculatio precox or from diminished potency; and,

(*d*) In those whose husbands practice coitus interruptus or reservatus. These cases go together, for on analyzing a large number of examples one can easily be convinced that they only depend on whether the woman attained gratification during coitus or not. In the latter case one finds the determinant for the origin of anxiety neurosis. On the other hand the woman is spared from the neurosis if the husband afflicted by ejaculatio precox can repeat the congress with better results immediately thereafter.

The congressu reservatus by means of the condom is not injurious to the woman if she is quickly excited and the husband is very potent; in other cases the noxiousness of this kind of preventive measure is not inferior to the others. Coitus interruptus is almost regularly injurious; but for the woman it is injurious only if the husband practices it regardlessly, that is, if he interrupts coitus as soon as he comes near ejaculating without concerning himself about the determination of the excitement of his wife. On the other hand if the husband waits until his wife is gratified, the coitus has the same significance for the latter as a normal one; but then the husband becomes afflicted with an anxiety neurosis. I have collected and analyzed a number of cases which furnished the material for the above statements.

(*e*) As fear in widows and intentional abstainers, not seldom in typical combination with obsessions; and,

(*f*) As fear in the climacterium during the last marked enhancement of the sexual desire.

The cases (*c*), (*d*), and (*e*) contain the determinants under which the anxiety neurosis originates in the female sex, most frequently and most independently, of hereditary predisposition. I will endeavor to demonstrate in these—curable, acquired—cases of anxiety neurosis that the discovered sexual injuries really represent the etiological moments of the neurosis. But before proceeding I will mention the sexual determinants of anxiety neurosis in men. I would like to formulate the following groups, every one of which finds its analogy in women:

(*a*) Fear of the intentional abstainers; this is frequently combined with symptoms of defense (obsessions, hysteria). The motives which are decisive for intentional abstinence carry along with them the fact that a number of hereditarily burdened eccentrics, etc., belong to this category.

(*b*) Fear in men with frustrated excitement (during the engagement period), persons who out of fear for the consequences of sexual relations satisfy themselves with handling or looking at the woman. This group of determinants which can moreover be transferred to the other sex—engagement periods, relations with sexual forbearance—furnish the purest cases of the neurosis.

(*c*) Fear in men who practice coitus interruptus. As observed above, coitus interruptus injures the woman if it is practiced

regardless of the woman's gratification; it becomes injurious to the man if in order to bring about the gratification in the woman he voluntarily controls the coitus by delaying the ejaculation. In this manner we can understand why it is that in couples who practice coitus interruptus it is usually only one of them who becomes afflicted. Moreover the coitus interruptus only rarely produces in man a pure anxiety neurosis, usually it is a mixture of the same with neurasthenia.

(*d*) Fear in men in the senium. There are men who show a climacterium like women, and merge into an anxiety neurosis at the time when their potency diminishes and their libido increases.

Finally I must add two more cases holding true for both sexes:

(*e*) Neurasthenics merge into anxiety neurosis in consequence of masturbation as soon as they refrain from this manner of sexual gratification. These persons have especially made themselves unfit to bear abstinence.

What is important for the understanding of the anxiety neurosis is the fact that any noteworthy development of the same occurs only in men who remain potent, and in non-anesthetic women. In neurasthenics, who on account of masturbation have markedly injured their potency, anxiety neurosis as a result of abstinence occurs but rarely and limits itself usually to hypochondria and light chronic dizziness. The majority of women are really to be considered as "potent"; a real impotent, that is, a real anesthetic woman, is also inaccessible to anxiety neurosis, and bears strikingly well the injuries cited.

How far we are perhaps justified in assuming constant relations between individual etiological moments and individual symptoms from the complex of anxiety neurosis, I do not care to discuss here.

(*f*) The last of the etiological determinants to be mentioned seems, in the first place, really not to be of a sexual nature. Anxiety neurosis originates in both sexes through the moment of overwork, exhaustive exertion, as, for instance, after sleepless nights, nursing the sick, and even after serious illnesses.

The main objection against my formulation of a sexual etiology of the anxiety neurosis will probably be to the purport that such abnormal relations of the sexual life can be found so very often

that wherever one will look for them they will be found near at hand. Their occurrence, therefore, in the cases cited of anxiety neurosis does not prove that the etiology of the neurosis was revealed in them. Moreover, the number of persons practicing coitus interruptus, etc., is incomparably greater than the number of those who are burdened with anxiety neurosis, and the overwhelming number of the first are quite well in spite of this injury.

To this I can answer that we certainly ought not to expect a rarely occurring etiological moment in the conceded enormous frequency of the neurosis, and especially anxiety neurosis; furthermore, that it really fulfills a postulate of pathology if on examining an etiology the etiological moments can be more frequently demonstrated than their effects, for, for the latter still other determinants (predisposition, summation of the specific etiology, reinforcement through other banal injuries) could be demanded; and furthermore, that the detailed analysis of suitable cases of anxiety neurosis show quite unequivocally the significance of the sexual moment. I shall, however, here confine myself to the etiological moment of coitus interruptus, and I will render prominent obvious individual experiences.

1. As long as the anxiety neurosis in young women is not yet constituted but appears in fragments which again spontaneously disappear, it can be shown that every such turn of the neurosis depends on a coitus with lack of gratification. Two days after this influence, and in persons of little resistance the day after, there regularly appears the attack of anxiety or vertigo to which all the other symptoms of the neurosis attach themselves, only to separate again on rarer marriage relations. An unexpected journey of the husband, a sojourn in the mountains causing a separation of the married couple, does good; the benefit from a course of gynecological treatment is due to the fact that during its continuation the marriage relations are stopped. It is noteworthy that the success of a local treatment is only transitory, the neurosis reappears while in the mountains if the husband joins his wife for his own vacation, etc. If, in a not as yet constituted neurosis, a physician aware of this etiology causes a substitution of the coitus interruptus by normal relations there results a therapeutic proof of the assertion here formulated. The anxiety

is removed and does not return unless there be a new or similar cause.

2. In the anamnesis of many cases of anxiety neurosis we find in both men and women a striking fluctuation in the intensity of the appearances in both the coming and going of the whole condition. This year was almost wholly good, the following was terrible, etc.; on one occasion the improvement occurred after a definite treatment which, however, failed to produce a response at the next attack. If we inform ourselves about the number and the sequence of the children, and compare this marriage chronicle with the peculiar course of the neurosis, the result of the simple solution shows that the periods of improvement or well being corresponded with the pregnancies of the woman during which, naturally, the occasions for preventive relations were unnecessary. The treatment which benefited the husband, be it Father Kneip's or the hydrotherapeutic institute, was the one which he has taken after he found his wife was pregnant.

3. From the anamnesis of the patients we often find that the symptoms of the anxiety neurosis are relieved at a certain time by another neurosis, perhaps a neurasthenia which has supplanted it. It can then be regularly demonstrated that shortly before this change of the picture there occurred a corresponding change in the form of a sexual injury.

Whereas such experiences, which can be augmented at pleasure, plainly obtrude upon the physician the sexual etiology for a certain category of cases, other cases which would have otherwise remained incomprehensible can at least without gainsaying be solved and classified by the key of the sexual etiology. We refer to those numerous cases in which everything exists that has been found in the former category, such as the appearance of anxiety neurosis on the one hand, and the specific moment of the coitus interruptus on the other, but yet something else slips in, namely, a long interval between the assumed etiology and its effect, and perhaps other etiological moments of a non-sexual nature. We have here, for example, a man who was seized with an attack of palpitation on hearing of his father's death, and who since that time suffered from an anxiety neurosis. The case cannot be understood, for up to that time this man was not nervous. The death of the father, well advanced in years, did not occur

under any peculiar circumstances, and it must be admitted that the natural expected death of an aged father does not belong to those experiences which are wont to make a healthy adult sick. The etiological analysis will perhaps seem clearer if I add that out of regard for his wife this man practiced coitus interruptus for eleven years. At all events the manifestations are precisely the same as those appearing in other persons after a short sexual injury of this nature, and without the intervention of another trauma. The same judgment may be pronounced in the case of a woman who merges into an anxiety neurosis after the death of her child, or in the case of the student who becomes disturbed by an anxiety neurosis while preparing for his final state examination. I find that here, as there, the effect is not explained by the reported etiology. One must not necessarily "overwork" himself studying, and a healthy mother is wont to react to the death of her child with normal grief. But, above all, I would expect that the overworked student would acquire a cephalasthenia, and that mother in our example a hysteria. That both became afflicted with anxiety neurosis causes me to attach importance to the fact that the mother lived for eight years in marital coitus interruptus, and that the student entertained for three years a warm love affair with a "respectable" girl whom he was not allowed to impregnate.

These examples tend to show that where the specific sexual injury of the coitus interruptus is in itself unable to provoke an anxiety neurosis it at least predisposes to its acquisition. The anxiety neurosis then comes to light as soon as the effect of another banal injury enters into the latent effect of the specific moment. The former can quantitatively substitute the specific moment but not supplant it qualitatively. The specific moment always remains that which determines the form of neurosis. I hope to be able to prove to a greater extent this proposition for the etiology of the neurosis.

Furthermore, the last discussions contain the, not in itself, improbable assumption that a sexual injury like coitus interruptus asserts itself through summation. The time required before the effect of this summation becomes visible depends upon the predisposition of the individual and the former burdening of his nervous system. The individuals who bear coitus interruptus

manifestly without disadvantage really become predisposed by it to the disturbance—anxiety neurosis—which can at any time burst forth spontaneously or after a banal, otherwise inadequate, trauma, just as the chronic alcoholic finally develops a cirrhosis or another disease by summation, or under the influence of a fever he merges into a delirium.

III. Addenda to the Theory of Anxiety Neurosis.

The following discussions claim nothing but the value of a first tentative experiment, which judgment should not influence the acceptance of the facts mentioned above. The estimation of this "Theory of Anxiety Neurosis" is rendered still more difficult by the fact that it merely corresponds to a fragment of a more comprehensive representation of the neuroses.

The facts hitherto expressed concerning the anxiety neurosis already contain some starting points for an insight into the mechanism of this neurosis. In the first place it contains the assumption that we deal with an accumulation of excitement, and then the very important fact that the anxiety underlying the manifestations of the neurosis is not of psychic derivation. Such, for example, would exist if we found as a basis for the anxiety neurosis a justified fright happening once or repeatedly which has since supplied the source of the preparedness for the anxiety neurosis. But this is not the case; a former fright can perhaps cause a hysteria or a traumatic neurosis but never an anxiety neurosis. As the coitus interruptus is rendered so prominent among the causes of anxiety neurosis I have thought at first that the source of the continuous anxiety was perhaps the repeated fear during the sexual act lest the technique will fail and conception follow. But I have found that this state of mind of the man or woman during the coitus interruptus plays no part in the origin of anxiety neurosis, that the women who are really indifferent to the possibilities of conception are just as exposed to the neurosis as those who are trembling at the possibility of it, it all depends on which person suffers the loss of sexual gratification.

Another starting point presents itself in the as yet unmentioned observation that in a whole series of cases the anxiety neurosis goes along with the most distinct diminution of the sexual libido or the psychic desire, so that on revealing to the patients that their

affliction depends on "insufficient gratification," they regularly reply that this is impossible as just now their whole desire is extinguished. The indications that we deal with an accumulation of excitement, that the anxiety which probably corresponds to such accumulated excitement is of somatic origin, so that somatic excitement becomes accumulated, and furthermore, that this somatic excitement is of a sexual nature, and that it is accompanied by a decreased psychic participation in the sexual processes—all these indications, I say, favor the expectation that the mechanism of the anxiety neurosis is to be found in the deviation of the somatic sexual excitement from the psychic, and in the abnormal utilization of this excitement.

This conception of the mechanism of anxiety neurosis will become clearer if one accepts the following view concerning the sexual process in man. In the sexually mature male organism, the somatic sexual excitement is—probably continuously—produced, and this becomes a periodic stimulus for the psychic life. To make our conceptions clearer we will add that this somatic sexual excitement manifests itself as a pressure on the wall of the seminal vesicle which is provided with nerve endings. This visceral excitement thus becomes continuously increased, but not before attaining a certain height is it able to overcome the resistances of the intercalated conduction as far as the cortex, and manifest itself as psychic excitement. Then the group of sexual ideas existing in the psyche becomes endowed with energy and results in a psychic state of libidinous tension which is accompanied by an impulse to remove this tension. Such psychic unburdening is possible only in one way which I wish to designate as specific or adequate action. This adequate action for the male sexual impulse consists of a complicated spinal reflex-act which results in the unburdening of those nerve endings, and of all psychically formed preparations for the liberation of this reflex. Anything else except the adequate action would be of no avail, for after the somatic sexual excitement has once reached the liminal value, it continuously changes into psychic excitement; that must by all means occur which frees the nerve endings from their heavy pressure, and thus abolish the whole somatic excitement existing at the time and allow the subcortical conduction to reëstablish its resistance.

I will desist from presenting in a similar manner more complicated cases of the sexual process. I will merely formulate the statement that this scheme can essentially be transferred to the woman despite the problem of the perplexity, artificial retardation, and stunting of the female sexual impulse. In the woman, too, it can be assumed that there is a somatic sexual excitement and a state in which this excitement becomes psychic, evoking libido and the impulse to specific action which is accompanied by the sensual feeling. But we are unable to state what analogy there may be in the woman to the unburdening of the seminal vesicles.

We can bring into the bounds of this representation of the sexual process the etiology of actual neurasthenia as well as of the anxiety neurosis. Neurasthenia always originates whenever the adequate (action) unburdening is replaced by a less adequate one, like the normal coitus under the most favorable conditions, by a masturbation or spontaneous pollution; while anxiety neurosis is produced by all moments which impede the psychic elaboration of the somatic sexual excitement. The manifestations of anxiety neurosis are brought about by the fact that the somatic sexual excitement diverted from the psyche expends itself subcortically in not at all adequate reactions.

I will now attempt to test the etiological determinants suggested before in order to see whether they show the common character formulated by me. As the first etiological moment for the man, I have mentioned intentional abstinence. Abstinence consists in foregoing the specific action which results from the libido. Such foregoing may have two consequences, namely, that the somatic excitement accumulates, and then, what is more important, is the fact that it becomes diverted to another route where there is more chance for discharge than through the psyche. It will then finally diminish the libido and the excitement will manifest itself subcortically as anxiety. Where the libido does not become diminished, or the somatic excitement is expended in pollutions, or where it really becomes exhausted in consequence of repulsion, everything else except anxiety neurosis is formed. In this manner abstinence leads to anxiety neurosis. But abstinence is also the active process in the second etiological group of frustrated excitement. The third case, that of the considerate coitus reser-

vatus, acts through the fact that it disturbs the psychic preparedness for the sexual discharge by establishing beside the subjugation of the sexual affect, another distracting psychic task. Through this psychic distraction, too, the libido gradually disappears and the further course is then the same as in the case of abstinence. The anxiety in old age (climacterium of men) requires another explanation. Here the libido does not diminish, but just as in the climacterium of women, such an increase takes place in the somatic excitement that the psyche shows itself relatively insufficient for the subjugation of the same.

The subsummation of the etiological determinants in the woman, under the aspect mentioned, does not afford any greater difficulties. The case of the virginal fear is especially clear. Here the group of ideas with which the somatic sexual excitement should combine are not as yet sufficiently developed. In anesthetically newly married the anxiety appears only if the first cohabitations awakened a sufficient amount of somatic excitement. Where the local signs of such excitability (like spontaneous feelings of excitement, desire to micturate, etc.) are lacking, the anxiety, too, stays away. The case of ejaculatio precox or coitus interruptus is explained similarly to that in the man by the fact that the libido gradually disappears in the psychically ungratified act, whereas the excitement thereby evoked is subcortically expended. The formation of an estrangement between the somatic and psychic in the discharge of the sexual excitement succeeds quicker in the woman than in the man and is more difficult to remove. The case of widowhood or voluntary abstinence, as well as the case of climacterium adjusts itself in the woman as in the man, but in the case of abstinence there surely is in addition the intentional repression of the sexual ideas, for an abstinent woman struggling with temptation must often decide to suppress it. The abhorrence perceived by an elderly woman during her menopause against the immensely increased libido can have a similar effect.

The two etiological determinants mentioned last can also be classified without any difficulty.

The tendency to anxiety of the masturbator who becomes neurasthenic is explained by the fact that these persons so easily merge into the state of abstinence after they have for long been

accustomed to afford a discharge, to be sure an incorrect one, for every little quantity of somatic excitement. Finally the last case, the origin of anxiety neurosis through a severe illness, overwork, exhaustive nursing, etc., in addition to the efficacy of coitus interruptus readily permits a free interpretation. Through deviation the psyche becomes here insufficient for the subjugation of the somatic sexual excitement, a task which continuously devolves upon it. We know how deeply the libido can sink under the same conditions, and we have here a nice example of a neurosis which although not of a sexual etiology still evinces a sexual mechanism.

The conception here developed represents the symptoms of anxiety neurosis in a measure as a substitute for the omitted specific action to the sexual excitement. As a further corroboration of this I recall that also in normal coitus the excitement extends itself in respiratory acceleration, palpitation, perspiration, congestion, etc. In the corresponding attack of anxiety of our neurosis we have before us the dyspnoea, the palpitation, etc., of the coitus in an isolated and aggravated manner.

It can still be asked why the nervous system merges into a peculiar affective state of anxiety under the circumstances of psychic inadequacy for the subjugation of the sexual excitement? A hint to the answer is as follows: The psyche merges into the affect of fear when it perceives itself unable to adjust an externally approaching task (danger) by corresponding reaction; it merges into the neurosis of anxiety when it finds itself unable to equalize the endogenously originated (sexual) excitement. The psyche, therefore, behaves as if projecting this excitement externally. The affect and the neurosis corresponding to it stand in close relationship to each other; the first is the reaction to an exogenous, the latter the reaction to an analogous endogenous excitement. The affect is a rapidly passing state, the neurosis is chronic because the exogenous excitement acts like a stroke happening but once, while the endogenous acts like a constant force. The nervous system reacts in the neurosis against an inner source of excitement just as it does in the corresponding affect against an analogous external one.

IV. The Relations to Other Neuroses.

A few observations still remain to be mentioned on the relations of the anxiety neurosis to the other neuroses in reference to occurrence and inner relationship.

The purest cases of anxiety neurosis are also usually the most pronounced. They are found in potent young individuals with a uniform etiology, and where the disease is not of long standing.

To be sure, the symptoms of anxiety are found more frequently as a simultaneous and common occurrence with those of neurasthenia, hysteria, compulsive ideas, and melancholia. If on account of such clinical mixtures one hesitates in recognizing anxiety neurosis as an independent unity, he will also have to abandon the laboriously acquired separation of hysteria and neurasthenia.

For the analysis of the "mixed neuroses" I can advocate the following proposition: Where a mixed neurosis exists, an involvement of many specific etiologies can be demonstrated.

Such a multiplicity of etiological moments determining a mixed neurosis can only come about accidentally, if the activities of a newly formed injury are added to those already existing. Thus, for example, a woman who was at all times a hysteric begins to practice coitus reservatus at a certain period of her married life, and adds an anxiety neurosis to her hysteria; a man who had masturbated and become neurasthenic, becomes engaged and excites himself with his fiancée so that a fresh anxiety neurosis allies itself to his neurasthenia.

The multiplicity of etiological moments in other cases is not accidental, one of them has brought the other into activity. Thus, a woman, with whom her husband practices coitus reservatus without regard to her gratification, finds herself forced to finish the tormenting excitement following such an act with masturbation, as a result of which she shows an anxiety neurosis with symptoms of neurasthenia. Under the same noxiousness another woman has to contend with lewd pictures against which she wishes to defend herself, and in this way the coitus interruptus will cause her to acquire obsessions along with the anxiety neurosis. Finally a third woman, as a result of coitus interruptus loses her affection for her husband and forms another which she

secretly guards, and as a result she evinces a mixture of hysteria and anxiety neurosis.

In a third category of mixed neuroses the connection of the symptoms is of a still more intimate nature, as the same etiological determinants regularly and simultaneously evoke both neuroses. Thus, for example, the sudden sexual explanation which we have found in virginal fear always produces hysteria, too; most causes of intentional abstinence connect themselves in the beginning with actual obsessions; and it seems to me that the coitus interruptus of men can never provoke a pure anxiety neurosis, but always a mixture of the same with neurasthenia, etc.

It follows from this discussion that the etiological determinants of the occurrence must moreover be distinguished from the specific etiological moments of neurasthenia. The first moments, as for example the coitus interruptus, masturbation, and abstinence, are still ambiguous, and can each produce different neuroses; and it is only the etiological moments abstracted from them, like the inadequate unburdening, psychic insufficiency, and defense with substitution, that have an unambiguous and specific relation to the etiology of the individual great neuroses.

In its intrinsic property, anxiety neurosis shows the most interesting agreements and differences when compared with the other great neuroses, particularly when compared with neurasthenia and hysteria. With neurasthenia it shares one main character, namely, that the source of excitement, the cause of the disturbance, lies in the somatic rather than in the psychic sphere as in the case of hysteria and compulsion neurosis. For the rest we can recognize a kind of contrast between the symptoms of neurasthenia and anxiety neurosis, which can be expressed in the catchwords, accumulation and impoverishment of excitement. This contrast does not hinder the two neuroses from combining with each other, but shows itself in the fact that the most extreme forms in both cases are also the purest.

When compared with hysteria anxiety neurosis shows in the first place a number of agreements in the symptomatology the valuation of which is still unsettled. The appearance of the manifestations as persistent symptoms or attacks, the aura-like grouped paresthesias, the hyperesthesias and pressure points can

be found in certain substitutes for the anxiety attack, as in dyspnoea and palpitation, the aggravation of the perhaps organically determined pains (by conversion)—these and other joint features lead to the supposition that some things which are ascribed to hysteria can with full authority be fastened to anxiety neurosis. But if we enter into the mechanism of both neuroses, as far as it can at present be penetrated, we find aspects which make it appear that the anxiety neurosis is really the somatic counterpart to hysteria. Here as there we have accumulation and excitement —on which is perhaps based the similarity of the aforementioned symptoms—; here as there we have a psychic insufficiency which results from abnormal somatic processes; and here as there we have instead of a psychic elaboration a deviation of the excitement into the somatic. The difference only lies in the fact that the excitement, in which displacement the neurosis manifests itself, is purely somatic (somatic sexual excitement) in anxiety neurosis, while in hysteria it is psychic (evoked through a conflict). Hence it is not surprising that hysteria and anxiety neurosis lawfully combine with each other, as in the "virginal fear" or in the "sexual hysteria," and that hysteria simply borrows a number of symptoms from anxiety neurosis, etc. This intimate relationship between anxiety neurosis and hysteria furnishes us with a new argument for demanding the separation of anxiety neurosis from hysteria, for if this be denied, one will also be unable to maintain the so painstakingly acquired distinction between neurasthenia and hysteria, so indispensable for the theory of the neuroses.

CHAPTER VII.

Further Observations on the Defense-Neuropsychoses.

Under the caption of "Defense-Neuropsychoses" I have comprised hysteria, obsessions, as well as certain cases of acute hallucinatory confusion.[1] All these affections evince one common aspect in the fact that their symptoms originated through the psychic mechanism of (unconscious) defense, that is, through the attempt to repress an unbearable idea which appeared in painful contrast to the ego of the patient. I was also able to explain and exemplify by cases reported in the preceding chapters in what sense this psychic process of "defense" or "repression" is to be understood. I have also discussed the laborious but perfectly reliable method of psychoanalysis of which I make use in my examinations, and which at the same time serves as a therapy.

My experiences during the last two years have strengthened my predilection for making the defense the essential point in the psychic mechanism of the mentioned neuroses, and on the other hand have permitted me to give a clinical foundation to the psychological theory. To my surprise I have discovered some simple but sharply circumscribed solutions for the problem of the neuroses which I shall provisionally briefly report in the following pages. It would be inconsistent with this manner of reporting to add to the assertions the required proofs, but I hope to be able to fulfill this obligation in a comprehensive discussion.

I. The "Specific" Etiology of Hysteria.

That the symptoms of hysteria become comprehensible only through a reduction to "traumatically" effective experiences, and that these psychic traumas refer to the sexual life has already been asserted by Breuer and me in former publications. What I have to add today as a uniform result of thirteen analyzed cases of hysteria concerns, on the one hand, the nature of these sexual traumas, and on the other, the period of life in which they oc-

[1] Neurologisches Centralblatt, 1896, Nr. 10.

curred. An experience occurring at any period of life, touching in any way the sexual life, and then becoming pathogenic through the liberation and suppression of a painful affect is not sufficient for the causation of hysteria. It must on the contrary belong to the sexual traumas of early childhood (the period of life before puberty), and its content must consist in a real irritation of the genitals (coitus-like processes).

This specific determination of hysteria—sexual passivity in pre-sexual periods—I have found fulfilled in all analyzed cases of hysteria (among which were two men). To what extent the determination of the accidental etiological moment diminishes the requirement of the hereditary predisposition needs only be intimated. We can, moreover, understand the disproportionately greater frequency of hysteria in the female sex, as even in childhood this sex is more subject to sexual assaults.

The objection most frequently advanced against this result may be to the purport, that sexual assaults on little children occur too frequently to give an etiological value to its verification, or that such experiences must remain ineffectual just because they concern a sexually undeveloped being; and that one must moreover be careful not to obtrude upon the patient through the examination such alleged reminiscences or believe in the romances which they themselves fabricate. To the latter objections I hold out the request that no one should really judge with great certainty this obscure realm unless he has made use of the only method which can clear it up (the method of psychoanalysis for bringing to consciousness the hitherto unconscious[2]). The essential point in the first doubts is settled by the observation that it really is not the experiences themselves that act traumatically, but their revival as reminiscences after the individual has entered into sexual maturity.

My thirteen cases of hysteria were throughout of the graver kind, they were all of long duration, and some had undergone a lengthy and unsuccessful asylum treatment. Every one of the infantile traumas which the analysis revealed for their severe cases had to be designated as marked sexual injuries; some of

[2] I myself surmise that the so frequently fabricated assaults of hysterical persons are obsessional confabulations emanating from the memory traces of infantile traumas.

them were indeed abominable. Among the persons who were guilty of such serious abuse we have in the first place nurses, governesses, and other servants to whom children are left much too carelessly, then in regrettable frequency come the teachers; but in seven of the thirteen cases we dealt with innocent childish offenders, mostly brothers who for years entertained sexual relations with their younger sisters. The course of events always resembled some of the cases which could with certainty be tracked, namely, that the boy had been abused by a person of the feminine sex, thus awakening in him prematurely the libido, and that after a few years he repeated in sexual aggression on his sister the same procedures to which he himself was subjected.

I must exclude active masturbation from the list of sexual injuries of early childhood as being pathogenic for hysteria. That it is so very frequently found associated with hysteria is due to the fact that masturbation in itself is more frequently the result of abuse or seduction than one supposes. It not seldom happens that both members of a childish pair later in life become afflicted by defense neuroses, the brother by obsessions and the sister by hysteria, which naturally gives the appearance of a familial neurotic predisposition. This pseudo-heredity is now and then solved in a surprising manner. I have had under observation a brother, sister, and a somewhat older cousin. The analysis which I have undertaken with the brother showed me that he suffered from reproaches for being the cause of his sister's malady; he himself was corrupted by his cousin, concerning whom it was known in the family that he fell a victim to his nurse.

I can not definitely state up to what age sexual damage occurs in the etiology of hysteria, but I doubt whether sexual passivity can cause repression after the eighth and tenth year unless qualified for it by previous experiences. The lower limit reaches as far as memory in general, that is, to the delicate age of one and one half or two years! (two cases). In a number of my cases the sexual trauma (or the number of traumas) occurred during the third and fourth year of life. I myself would not lend credence to this peculiar discovery if it were not for the fact that the later development of the neurosis furnished it with full trustworthiness. In every case there are a number of morbid symp-

toms, habits and phobias which are only explainable by returning to those youthful experiences, and the logical structure of the neurotic manifestation makes it impossible to reject the faithfully retained memories of childhood. Except through psychoanalysis it is of no avail to ask a hysterical patient about these infantile traumas; their remains can only be found in the morbid symptoms and not in conscious memory.

All the experiences and excitements which prepare the way for, or occasion the outburst of, hysteria in the period of life after puberty evidently act through the fact that they awaken the memory remnants of those infantile traumas which do not become conscious but lead to the liberation of affect and repression. It is quite in harmony with this rôle of the later traumas not to be subject to the strict limitation of the infantile traumas, but that both in intensity and quality they can vary from an actual sexual assault to a mere approximation of the sexual, such as perceiving the sexual acts of others, or receiving information concerning sexual processes.[3]

In my first communication on the defense neuropsychoses I failed to explain how the exertion of a hitherto healthy individual to forget such traumatic happenings would result in the real intentional repression, and thus open the door for the defense neurosis. It can not depend on the nature of the experience, as other persons remain unaffected despite the same motives. Hysteria cannot therefore be fully explained by the effect of the trauma, and we are forced to admit that the capacity for hysteria already existed before the trauma.

This indefinite hysterical predisposition can now wholly or partially be substituted by the posthumous effect of the infantile sexual trauma. The "repression" of the memory of a painful sexual experience of maturer years can take place only in per-

[3] In an article on the anxiety neurosis (Neurologisches Centralblatt, 1895, Nr. 2) I stated that "an anxiety neurosis which can almost typically be combined with hysteria can be evoked in maturing girls at the first encounter with the sexual problem." I know today that the occasion in which such virginal anxiety breaks out does not really correspond to the first encounter with sexuality, but that in such persons there was in childhood a precedent experience of sexual passivity which memory was awakened at the "first encounter."

sons in whom this experience can bring into activity the memory remnants of an infantile trauma.[4]

The prerequisite of obsessions is also a sexual infantile experience, but of a different nature than that of hysteria. The etiology of both defense neuropsychoses now shows the following relation to the etiology of both simple neuroses, neurasthenia and anxiety neurosis. As I have shown above, both the latter neuroses are the direct results of the sexual noxas alone, while both defense neuroses are the direct results of sexual noxas which acted before the appearance of sexual maturity that is, they are the results of the psychic memory remnants of these noxas. The actual causes producing neurasthenia and anxiety neurosis simultaneously play the rôle of inciting causes of the defense neuroses, and on the other hand, the specific causes of the defense neuroses, the infantile traumas, may simultaneously prepare the soil for the later developing neurasthenia. Finally it not seldom happens that the existence of a neurasthenia or anxiety neurosis is only preserved by continued recollection of an infantile trauma rather than by actual sexual injuries.

[4] A psychological theory of the repression ought also to inform us why only ideas of a sexual content can be repressed. It may be formulated as follows: It is known that ideas of a sexual content produce exciting processes in the genitals resembling the actual sexual experience. It may be assumed that this somatic excitement becomes transformed into psychic. As a rule the activity referred to is much stronger at the time of the occurrence than at the recollection of the same. But if the sexual experience takes place during the time of sexual immaturity and the recollection of the same is awakened during or after maturity, the recollection then acts disproportionately more exciting than the previous experience, for puberty has in the mean time incomparably increased the reactive capacity of the sexual apparatus. But such an inverse proportion seems to contain the psychological determination of repression. Through the retardation of the pubescent maturity in comparison with the psychic function, the sexual life offers the only existing possibility for that inversion of the relative efficacy. The infantile traumas subsequently act like fresh experiences, but they are then unconscious. Deeper psychological discussions I will have to postpone for another time. I moreover call attention to the fact that the here considered time of "sexual maturity" does not coincide with puberty, but occurs before the same (eight to ten years).

II. The Essence and Mechanism of Compulsion Neurosis.

Sexual experiences of early childhood have the same significance in the etiology of the compulsion neurosis as in hysteria, still we no longer deal here with sexual passivity but with pleasurably accomplished aggressions, and with pleasurably experienced participation in sexual acts, that is, we deal here with sexual activity. It is due to this difference in the etiological relations that the masculine sex seems to be preferred in the compulsion neurosis.

In all my cases of compulsion neurosis I have found besides a sub-soil of hysterical symptoms which could be traced to a pleasurable action of sexual passivity from a precedent scene. I presume that this coincidence is a lawful one and that premature sexual aggression always presupposes an experience of seduction. But I am unable to present as yet a complete description of the etiology of the compulsion neurosis. I only believe that the final determination as to whether a hysteria or compulsion neurosis should originate on the basis of infantile traumas depends on the temporal relation of the development of the libido.

The essence of the compulsion neurosis may be expressed in the following simple formula: Obsessions are always transformed *reproaches* returning from the repression which always refer to a pleasurably accomplished sexual action of childhood. In order to elucidate this sentence it will be necessary to describe the typical course of compulsion neurosis.

In a first period—period of childish immorality—the events containing the seeds of the later neurosis take place. In the earliest childhood there appear at first the experiences of sexual seduction which later makes the repression possible, and this is followed by the actions of sexual aggressions against the other sex which later manifest themselves as actions of reproach.

This period is brought to an end by the appearance of the—often self ripened—sexual "maturity." A reproach then attaches itself to the memory of that pleasurable action, and the connection with the initial experience of passivity makes it possible—often only after conscious and recollected effort—to repress it and replace it by a primary symptom of defense. The third period, that of apparent healthiness but really of successful defense, begins with the symptoms of scrupulousness, shame and diffidence.

The next period, the disease is characterized by the return of the repressed reminiscences, hence, by the failure of the defense; but it remains undecided whether the awakening of the same is more frequently accidental and spontaneous, or whether it appears in consequence of actual sexual disturbances, that is, as additional influences of the same. But the revived reminiscences and the reproaches formed from them never enter into consciousness unchanged, but what becomes conscious as an obsession and obsessive affect and substitutes the pathogenic memory in the conscious life, are compromise formations between the repressed and the repressing ideas.

In order to describe clearly and probably convincingly the processes of repression, the return of the repression, and the formation of the pathological ideas of compromise, we would have to decide upon very definite hypotheses concerning the substratum of the psychic occurrence and consciousness. As long as we wish to avoid it we will have to rest content with the following rather figuratively understood observations. Depending on whether the memory content of the reproachful action alone forces an entrance into consciousness or whether it takes with it the accompanying reproachful affect, we have two forms of compulsion neurosis. The first represents the typical obsessions, the content of which attracts the patient's attention; only an indefinite displeasure is perceived as an affect, whereas, for the content of the obsession the only suitable affect would be one of reproach. The content of the obsession is doubtly distorted when compared to the content of the infantile compulsive act. First, something actual replaces the past experience, and second, the sexual is substituted by an analogous non-sexual experience. These two changes are the results of the constant tendency to the repression still in force which we will attribute to the "ego." The influence of the revived pathogenic memory is shown by the fact that the content of the obsession is still partially identical with the repressed, or can be traced to it by a correct stream of thought. If, with the help of the psychoanalytic method, we reconstruct the origin of one individual obsession we find that one actual impression instigated two diverse streams of thought, and that the one which passed over the repressed memory, though incapable of consciousness and correction, proves to be just as correctly

formed logically as the other. If the results of the two psychic operations disagree, the contradiction between the two may never be brought to logical adjustment, but as a compromise between the resistance and the pathological result of thought an apparently absurd obsession enters into consciousness beside the normal result of the thought. If both streams of thought yield the same result, they reinforce each other so that the normally gained result of thought now behaves psychically like an obsession. Wherever neurotic compulsion manifests itself psychically it originates from repression. The obsessions have, as it were, a psychical course of compulsion which is due, not to their own validity, but to the source from which they originate, or to the source which furnishes a part of their validity.

A second form of compulsion neurosis results if the repressed reproach and not the repressed content of memory forces a replacement in the conscious psychic life. Through a psychic admixture, the affect of the reproach can change itself into any other affect of displeasure, and if this occurs there is nothing to hinder the substituting affect from becoming conscious. Thus the reproach (of having performed in childhood some sexual actions) may be easily transformed into shame (if some one else becomes aware of it), into hypochondriacal anxiety (because of the physical harmful consequences of those reproachful acts), into social anxiety (fearing punishment from others), into religious anxiety, into delusions of observation (fear of betraying those actions to others), into fear of temptations (justified distrust in one's own moral ability of resistance), etc. Besides, the memory content of the reproachful action may also be represented in consciousness, or it may be altogether concealed, which makes the diagnosis very difficult. Many cases which on superficial examination are taken as ordinary (neurasthenic) hypochondria often belong to this group of compulsive affects; the very frequently so called "periodic neurasthenia" or "periodic melancholia" especially seem to be explained by compulsive affects or obsessions, a recognition not unimportant therapeutically.

Beside these compromise symptoms which signify the return of the repression and hence a failure of the originally achieved defense, the compusion neurosis forms a series of other symptoms of a totally different origin. The ego really tries to defend

itself against those descendants of the initial repressed reminiscence, and in this conflict of defense it produces symptoms which may be comprehended as "secondary defense." These are througout "protective measures" which have performed good service in the struggle carried on against the obsessions and the obsessing affects. If these helps in the conflict of the defense really succeed in repressing anew the symptoms of return obtruding themselves on the ego, the compulsion then transmits itself on the protective measures themselves and produces a third form of the "compulsion neurosis," the compulsive action. These are never primary, they never contain anything else but a defense, never an aggression. Psychic analysis shows that despite their peculiarity they can always be fully explained by reduction to the compulsive reminiscence which they oppose.[5]

The secondary defense of the obsessions can be brought about by a forcible deviation to other thoughts of possibly contrary content; hence, in case of success there is a compulsive reasoning, regularly concerning abstract and transcendental subjects, because the repressed ideas always occupied themselves with the sensuous.

[5] One example instead of many: An eleven-year-old boy has obsessively arranged for himself the following ceremonial before going to bed: He could not fall asleep unless he related to his mother most minutely all experiences of the day; not the smallest scrap of paper or any other rubbish was allowed in the evening on the carpet of his bedroom. The bed had to be moved close to the wall, three chairs had to stand in front of it, and the pillows had to lie in just such a position. In order to fall asleep he had to kick with both legs a number of times, and then had to lie on the side. This was explained as follows: Years before while putting this pretty boy to sleep, the servant girl made use of this opportunity to lay over him and assault him sexually. When this reminiscence was later awakened by a recent experience it made itself known to consciousness by the compulsion in the above mentioned ceremonial which sense could really be surmised and the details verified by psychoanalysis. The chairs before the bed which was close to the wall—so that no one could have access to it; the arrangement of the pillows in a definite manner—so that they should be differently arranged than they were on that evening; the motion with the legs—to kick away the person lying on him; sleeping on the side—because during that scene he lay on his back; the detailed confession to his mother—because in consequence of the prohibition of his seductress he concealed from his mother this and other sexual experiences; finally, keeping the floor of his bedroom clean—because this was the main reproach which he had to hear from his mother up to that time.

Or the patient tries to become master of every compulsive idea through logical labor and by appealing to his conscious memory; this leads to compulsive thinking and examination to doubting mania. The priority of the perception before the memory in these examinations at first induce and then force the patient to collect and preserve all objects with which he comes in contact. The secondary defense against the compulsive affects results in a greater number of defensive measures which are capable of being transformed into compulsive actions. These can be grouped according to their tendency. We may have measures of penitence (irksome ceremonial and observation of numbers), of prevention (diverse phobias, superstition, pedantry, aggravation of the primary symptom of scrupulousness), measures of fear of betrayal (collecting papers and shyness), and measures of becoming unconscious (dipsomania). Among these compulsive acts and impulses the phobias play the greatest part as limitations of the patient's existence.

There are cases in which we can observe how the compulsion becomes transferred from the idea or affect to the measure, and other cases in which the compulsion oscillates between the returning symptoms of secondary defense. But there are also cases in which no obsessions are really formed, but the repressed reminiscence immediately becomes replaced by the apparent primary defensive measure. Here that stage is attained at a bound which otherwise ends the course of the compulsion neurosis only after the conflict of the defense. Grave cases of this affection end either with a fixation of ceremonial actions, general doubting mania, or in an existence of eccentricity conditioned by phobias.

That the obsessions and everything derived from them are not believed is probably due to the fact that the defense symptom of scrupulousness was formed during the first repression and gained compulsive validity. The certainty of having lived morally throughout the whole period of the successful defense makes it impossible to give credence to the reproach which the obsession really involves. Only transitorily during the appearance of a new obsession, and now and then in melancholic exhaustive states of the ego do the morbid symptoms of the return also enforce the belief. The "compulsion" of the psychic formations here described has in general nothing to do with the recognition through

belief, and is not to be mistaken for that moment which is designated as "strength" or "intensity" of an idea. Its main characteristic lies in its inexplicableness through psychic activities of conscious ability, and this character undergoes no change whether the idea to which the compulsion is attached is stronger or weaker, more or less intensively "elucidated," "supplied with energy," etc.

The reason for the unassailableness of the obsession or its derivative is due only to its connection with the repressed memory of early childhood, for as soon as we succeed in making it conscious, for which the psycho-therapeutic methods already seem quite sufficient, the compulsion, too, becomes detached.

III. Analysis of a Case of Chronic Paranoia.

For some length of time I entertained the idea that paranoia also—or the group of cases belonging to paranoia—is a defense psychosis that is, like hysteria and obsessions it originates from the repression of painful reminiscences, and that the form of its symptoms is determined by the content of the repression. A special way or mechanism of repression must be peculiar to paranoia perhaps just as in hysteria which brings about the repression by way of conversion into bodily innervation, and perhaps like obsessions in which a substitution is accomplished (displacement along certain associative categories). I observed many cases which seemed to favor this interpretation, but I had not found any which demonstrated it until a few months ago when, through the kindness of Dr. J. Breuer, I subjected to psychoanalysis, with therapeutic aims, an intelligent woman of 32, whom no one will be able to refuse to designate as a chronic paranoiac. I report here some explanations gained in this work, because I have no prospects of studying paranoia except in very isolated examples, and because I think it possible that these observations may instigate a psychiatrist for whom conditions are more favorable, to give due justice to the moment of defense in the present animated discussion on the nature and psychic mechanism of paranoia. It is of course far from my thoughts to wish to show from the following single observation anything but that this case is a defense-psychosis, and that in the group of "paranoia" there may be still others of a similar nature.

Mrs. P. thirty-two years old, married three years. She is the mother of a two-year-old child, and does not descend from nervous parents; but her sister and brother, whom I know, are also neurotic. It was doubtful whether she was not transitorily depressed and mistaken in her judgment in the middle of her twentieth year. During the last years she was healthy and capacitated until she evinced the first symptoms of the present illness, six months after the birth of her child. She became secluded and suspicious, showing a disinclination towards social relations with the relatives of her husband, and complained that the neighbors in the little town now behaved towards her in a rather impolite and regardless manner. Gradually these complaints grew in intensity, she thought that there was something against her, though she had no notion what it could be. But there was no doubt that all the relatives and friends denied her respect, and did everything to aggravate her. She was trying very hard to find out whence this came but could not discover anything. Some time later she complained that she was watched, that her thoughts were guessed, and that everything that happened in her house was known. One afternoon she suddenly conceived the thought that she was watched during the evening while undressing. Since then she applied while undressing the most complicated precautionary measures. She slipped into her bed in the darkness and undressed only under cover. As she avoided all social relations, and took but little nourishment, and was very depressed, she was sent in the summer of 1895 to a hydrotherapeutic institute. There new symptoms appeared and reinforced those already existing. As early as the spring, while she was alone with the servant girl, she suddenly perceived a sensation in her lap, and thought that the servant girl then had an unseemly thought. This sensation became more frequent in the summer, it was almost continuous, and she felt her genitals "as if one feels a heavy hand." She then began to see pictures which frightened her; they were hallucinations of female nakedness, especially an exposed woman's lap with hair; occasionally she also saw male genitals. The picture of the hairy lap and the organic sensation in the lap usually came conjointly. The pictures became very aggravating, as she regularly perceived them when she was in the company of a woman, and the thought accompanying them

was that she sees the woman in an indecent exposure, and that in the same moment the woman sees the same picture of her (!) Simultaneously with these visual hallucinations, which, after their first appearance in the asylum, disappeared again for many months, she begain to be troubled with voices which she did not recognize and could not explain. When she was in the street she heard, "This is Mrs. P.—Here she goes.—Where does she go?" Everyone of her movements and actions were commented upon. Occasionally she heard threats and reproaches. All these symptoms became worse when she was in society, or even in the street; she therefore hesitated about going out; she also stated that she experienced nausea for food, and as a result she became reduced in vitality.

I obtained this from her when she came under my care in the winter of 1895. I present this case in detail in order to make the impression that we really deal here with a very frequent form of chronic paranoia, which diagnosis will agree with the details of the symptoms and their behavior to be mentioned later. At that time she either concealed from me the delusions for the interpretation of the hallucinations or they really had not as yet occurred. Her intelligence was undiminished. It was reported to me as peculiar that she had a number of rendezvous with her brother who lived in the neighborhood, in order to confide something to him, but this she never told him. She never spoke about her hallucinations, and towards the end she did not say much about the aggravations and persecutions from which she suffered. What I have to report about this patient concerns the etiology of the case and the mechanism of the hallucinations. I discovered the etiology by applying Breuer's method exactly as in hysteria, for the investigation and removal of the hallucinations. I started with the presupposition that just as in the two other defense neuroses known to me this paranoia must contain unconscious thoughts and repressed reminiscences which have to be brought to consciousness, in the same manner as in the others, by overcoming a certain resistance. The patient immediately corroborated this expectation by behaving during the analysis exactly like a hysteric, and under attention to the pressure of my hand she reproduced thoughts which she could not remember having had, which she at first could not un-

derstand, and which contradicted her expectations. The occurrence of important unconscious ideas was therefore also demonstrated in a case of paranoia, and I could hope to reconduct the compulsion of paranoia to repression. It was only peculiar that the assertions which originated in the unconscious were usually heard inwardly or hallucinated by her as her voices.

Concerning the origin of the visual hallucinations, or at least the vivid pictures, I discovered the following: The picture of the female lap occurred almost always together with the organic sensation in the lap. The latter, however, was more constant and often occurred without the picture.

The first pictures of feminine laps appeared in the hydrotherapeutic institute a few hours after she had actually seen a number of women naked in the bath house. They were therefore only simple reproductions of a real impression. It may be assumed that these impressions repeated themselves because something of great interest was connected with them. She stated that she was at that time ashamed of these women, and that since she recalled it she is ashamed of having been seen naked. Having been obliged to look upon this shame as something compulsive, I concluded that according to the mechanism of defense an experience must have here been repressed in which she was not ashamed, and I requested her to allow those reminiscences to emerge which belonged to the theme of shame. She promptly reproduced a series of scenes from her seventeenth to her eighth year, during which while bathing before her mother, her sister, and her physician she was ashamed of her nakedness. This series, however, reached back to a scene in her sixth year when she undressed in the children's room before going to sleep without feeling ashamed of her brother who was present. On questioning her it was found that there were a number of such scenes, and that for years the brothers and sisters were in the habit of showing themselves naked to one another before retiring. I now understood the significance of the sudden thought of being watched on going to sleep. It was an unchanged fragment of the old reproachful reminiscence and she was now trying to make up in shame what she lost as a child.

The supposition that we dealt here with an amour of childhood so frequent in the etiology of hysteria was strengthened by the

further progress of the analysis which also showed simultaneous solutions for individual frequently recurring details in the picture of paranoia. The beginning of her depression commenced at the time of a disagreement between her husband and her brother on account of which the latter no longer visited her. She was always much attached to this brother and missed him very much at this time. Besides this she spoke about a moment in the history of her disease during which for the first time "everything became clear," that is, during which she became convinced that her assumption about being generally despised and intentionally annoyed was true. She gained this assurance during a visit of her sister-in-law, who in the course of conversation dropped the words, "If such a thing should happen to me I would not mind it." Mrs. P. at first took this utterance unsuspectingly, but when her visitor left her it seemed to her that these words contained a reproach meaning that she was in the habit of taking serious matters lightly, and since that hour she was sure that she was a victim of common slander. On asking her why she felt justified in referring those words to herself she answered that the tone in which her sister-in-law spoke convinced her of it—to be sure subsequently—This is really a characteristic detail of paranoia. I now urged her to recall her sister-in-law's conversation before the accusing utterance, and it was found that she related that in her father's home there were all sorts of difficulties with the brothers, and added the wise remark, "In every family many things happen which one would rather keep under cover, and that if such a thing should happen to her she would take it lightly." Mrs. P. had to acknowledge that her depression was connected with the sentences before the last utterance. As she repressed both sentences which could recall her relations with her brother and retained only the last meaningless one, she was forced to connect with it the feeling of being reproached by her sister-in-law; but, inasmuch as the contents of this sentence offered absolutely no basis for such assumption she disregarded it and laid stress on the tone with which the words were pronounced. It is probably a typical illustration for the fact that the misinterpretations of paranoia depend on repression.

In a most surprising manner it also explains her peculiar behavior in making appointments with her brother and then re-

fusing to tell him anything. Her explanation was that she thought that if she only looked at him he must understand her suffering, as he knew the cause of it. As this brother was really the only person who could know anything about the etiology of her disease it followed that she acted from a motive which, though she did not consciously understand, seemed perfectly justified as soon as a new sense was put on it from the unconscious.

I then succeeded in causing her to reproduce different scenes the culminating points of which were the sexual relations with her brother at least from her sixth to her tenth year. During this work of reproduction the organic sensation in the lap "joined in the discussion," precisely as regularly observed in the analysis of memory remnants of hysterical patients. The picture of a naked female lap (but now reduced to childish proportions and without hair) immediately appeared or stayed away in accordance with the occurrence of the scene in question in full light or in darkness. The disgust for eating, too, was explained by a repulsive detail of these actions. After we had gone through this series, the hallucinatory sensations and pictures disappeared without having thus far returned.[6]

I have thus learned that these hallucinations were nothing other than fragments from the content of the repressed experiences of childhood, that is, symptoms of the return of the repressed material.

I now turned to the analysis of the voices. Here it must before all be explained why such indifferent remarks as, "Here goes Mrs. P.—She now looks for apartments, etc.," could be so painfully perceived, and how these harmless sentences managed to become distinguished by hallucinatory enforcement. To begin with, it was clear that these "voices" could not be hallucinatory reproduced reminiscences like the pictures and sensations, but rather thoughts which "became loud."

She heard the voices for the first time under the following circumstances. With great tension she read the pretty story,

[6] When the meagre success of this treatment was later removed by an exacerbation, she did not again see the offensive pictures of strange genitals, but she had the idea that strangers saw her genitals as soon as they were behind her.

"The Heiterethei" by O. Ludwig, and noticed that while reading she was preoccupied with incoming thoughts. Immediately after she took a walk on the highway and suddenly while passing a peasant's cottage the voices told her, "That is how the house of the Heiterethei looked! Here is the well, and here is the bush! How happy she was in all her poverty!" The voices then repeated whole paragraphs of what she had just read, but it remained incomprehensible why house, bush, and well of the Heiterethei, and just such indifferent and most irrelevant passages of the romance should have obtruded themselves upon her attention with pathological strength. The analysis showed that while reading she at the same time entertained extraneous thoughts, and that she was excited by totally different passages of the book. Against this material analogy between the couple of the romance and herself and her husband, the reminiscence of intimate things of her married life and family secrets, against all these there arose a repressive resistance because they were connected with her sexual shyness by very simple and demonstrable streams of thought, and finally resulted in the awakening of old experiences of childhood. In consequence of the censorship exercised by the repression the harmless and idyllic passages connected with the objectionable ones by contrast and vicinity, became reinforced in consciousness, enabling them to become audible. For example, the first repressed thought referred to the slander to which the secluded heroine was subjected by her neighbors. She readily found in this an analogy to herself. She, too, lived in a small place, had no intercourse with anybody and considered herself despised by her neighbors. The suspicion against the neighbors was founded on the fact that in the beginning of her married life she was obliged to content herself with a small apartment. The wall of the bedroom, near which stood the nuptial bed of the young couple, adjoined the neighbors' room. With the beginning of her marriage there awakened in her a great sexual shyness. This was apparently due to an unconscious awakening of some reminiscences of childhood of having played husband and wife. She was very careful lest the neighbors might hear through the adjacent wall either words or noises and this shyness changed into suspicion against the neighbors.

The voices therefore owed their origin to the repression of

thoughts which in the last analysis really signified reproaches on the occasion of an experience analogous to the infantile trauma; they were accordingly symptoms of the return of the repression, but at the same time they were results of a comparison between the resistance of the ego and the force of the returning repression which in this case produce a distortion beyond recognition. On other occasions when analyzing voices in Mrs. P. the distortion was less marked, still the words heard always showed a character of diplomatic uncertainty. The annoying allusion was generally deeply hidden, the connection of the individual sentences was masked by a strange expression, unusual forms of speech, etc., characteristics generally common to the auditory hallucinations of paranoiacs, and in which I noticed the remnant of the compromise distortion. The expression, "There goes Mrs. P., she is looking for apartments in the street," signified, for example, the threat that she will never recover, for I promised her that after the treatment she would be able to return to the little city where her husband was employed. She rented temporary quarters in Vienna for a few months.

On some occasions Mrs. P. also perceived more distinct threats, for example, concerning the relatives of her husband, the restrained expression of which still continued to contrast with the grief which such voices caused her. Considering all that we otherwise know of paranoiacs I am inclined to assume a gradual relaxation of that resistance which weakens the reproaches so that finally the defense fails completely and the original reproach, the insulting word, which one wanted to save himself returns in unchanged form. I do not, however, know whether this is a constant course, whether the censor of the expressions of reproach can not from the beginning stay away, or persist to the end.

It is left for me to utilize the explanations gained in this case of paranoia for the comparison of paranoia with compulsion neurosis. Here, as there, the repression was shown to be the nucleus of the psychic mechanism, and in both cases the repression is a sexual experience of childhood. The origin of every compulsion in this paranoia is in the repression, and the symptoms of paranoia allow a similar classification as the one found justified in compulsion neurosis. Some symptoms also originate from the primary defense among which are all delusions of distrust, sus-

picion and persecution by others. In the compulsion neurosis the initial reproach became repressed through the formation of the primary symptom of defense, self-distrust, moreover, the reproach was recognized as justified, and for the purpose of adjustment the validity acquired by the scrupulousness during the normal interval now guards against giving credence to the returning reproach in the form of an obsession. By the formation of the defense-symptom of distrust in others, the reproach in paranoia is repressed in a way which may be designated as projection; the reproach is also deprived of recognition, and as a retaliation there is no protection against the returning reproaches contained in the delusions.

The other symptoms in my case of paranoia are therefore to be designated as symptoms of the return of the repression, and as in the compulsion neurosis they show the traces of the compromise which alone permits an entrance into consciousness. Such are the delusions of being observed while undressing, the visual hallucination, the perceptual hallucinations and the hearing of voices. The memory content existing in the delusion mentioned is almost unchanged and appears only uncertain through utterance. The return of the repression into visual pictures comes nearer to the character of hysteria than to the character of compulsion neurosis; still, hysteria is wont to repeat its memory symbols without modification, whereas the paranoic memory hallucination undergoes a distortion similar to those in compulsion neurosis. An analogous modern picture takes the place of the one repressed (instead of a child's lap it was the lap of a woman upon which the hairs were particularly distinct because they were absent in the original impression). Quite peculiar to paranoia but no further elucidated in this comparison is the fact that the repressed reproaches return as loud thoughts, this must yield to a double distortion: (1) a censor, which either leads to a replacement through other associated thoughts or to a concealment by indefinite expressions, and (2) the reference to the modern which is merely analogous to the old.

The third group of symptoms found in compulsion neurosis, the symptoms of the secondary defense, cannot exist as such in paranoia, for no defense asserts itself against the returning symptoms which really find credence. As a substitute for this we find

in paranoia another source of symptom formation; the delusions (symptom of return) reaching consciousness through the compromise demand a great deal of the thinking work of the ego until they can be unconditionally accepted. As they themselves are not to be influenced the ego must adapt itself to them, and hence the combining delusional formation, the delusion of interpretation which results in the transformation of the ego, corresponds here to the symptoms of secondary defense of compulsion neurosis. In this respect my case was imperfect as it did not at that time show any attempt at interpretation, this only appeared later. I do not doubt, however, that if psychoanalysis were also applied to that stage of paranoia, another important result would be established. It would probably be found that even the so called weakness of memory in paranoiacs is purposeful, that is, it depends on the repression and serves its purpose. Subsequently even those non-pathogenic memories which stand in opposition to the transformation of the ego become repressed and replaced; this the symptoms of return imperatively demand.

CHAPTER VIII.

ON PSYCHOTHERAPY.[1]

Gentlemen:

It is almost eight years since, at the request of your deceased chairman, Prof. v. Reder, I had the pleasure of speaking in your midst on the subject of hysteria. Shortly before (1895) I had published the "Studien über Hysterie" together with Dr. J. Breuer, and on the basis of a new knowledge for which we are thankful to this investigator, I have attempted to introduce a new way of treating the neurosis. Fortunately, I can say that the endeavors of our "Studies" have met with success, and that the ideas which they advocate concerning the effects of psychic traumas through the restraint of affects and the conception of the hysterical symptom as a result of a displacement of excitement from the psychic to the physical—ideas for which we have created the terms "ab-reaction" and "conversion"—are today generally known and understood. At least in German-speaking countries there are no descriptions of hysteria which do not to a certain extent take cognizance of them, and no colleague who does not at least partially follow this theory. And yet as long as they were new these theories and these terms must have sounded strange enough!

I can not say the same thing about the therapeutic procedure which we have proposed to our colleagues together with our theory. It still struggles for recognition. This may have its special reasons. The technique of the procedure was at that time still rudimentary. I was unable to give those indications to the medical reader of the book which would enable him to perform such a treatment. But surely there were other causes of a general nature. To many physicians psychotherapy even today appears as a product of modern mysticism, and in comparison to our physico-chemical remedies the application of which is based on physiological insight, psychotherapy appears quite unscientific

[1] Lecture delivered before the Vienna Medic. Doktorenkollegium, on December 12, 1904.

and unworthy of the interest of a natural philosopher. You will therefore allow me to present to you the subject of psychotherapy, and to point out to you what part of this verdict can be designated as unjust or erroneous.

In the first place let me remind you that psychotherapy is not a modern therapeutic procedure. On the contrary it is one of the oldest remedies used in medicine. In Lëwenfeld's instructive work (Lehrbuch der gesamten Psychotherapie) you can find the methods employed in primitive and ancient medicine. Most of them were of a psychotherapeutic nature. In order to cure a patient he was transferred into a state of "credulous expectation" which acts in a similar manner even today. Even after the doctors found other remedial agents psychotherapeutic endeavors never disappeared from this or that branch of medicine.

Secondly, I call your attention to the fact that we doctors really can not abandon psychotherapy if only because another very much to be considered party in the treatment—namely the patient—has no intention of abandoning it. You know how much we owe to the Nancy school (Liébault, Bernheim) for these explanations. Without our intention, an independent factor from the patient's psychic disposition enters into the activity of every remedial agent introduced by the doctor, acting mostly in a favorable sense but often also in an inhibiting sense. We have learned to apply to this factor the word "suggestion," and Moebius taught us that the failures of some of our remedies are to be ascribed to the disturbing influences of this very powerful moment. You doctors, all of you, constantly practice psychotherapy, even when you do not know it, or do not intend it, but it has one disadvantage, you leave entirely to the patient the psychic factor of your influence. It then becomes uncontrollable, it can not be divided into doses and can not be increased. Is it not a justified endeavor of the doctor to become master of this factor, to make use of it intentionally, to direct and enforce it? It is nothing other than that, that scientific psychotherapy expects of you.

In the third place, gentlemen, I wish to refer you to the well known experience, namely, that certain maladies and particularly the psychoneuroses, are more accessible to psychic influences than to any other medications. It is no modern talk but a dictum of old physicians that these diseases are not cured by the drug,

but by the doctor, to wit, by the personality of the physician in so far as it exerts a psychic influence. I am well aware, gentlemen, that you like very much the idea which the asthete Vischer, in his parody on Faust (Faust, der Tragödie, III Teil) endowed with a classical expression: "I know that the physical often acts on the moral."

But would it not be more adequate and frequently more correct to influence the moral part of the person with the moral, that is, with psychic means?

There are many ways and means of psychotherapy. All methods are good which produce the aim of the therapy. Our usual consolation, "You will soon be well again," with which we are so generous to our patients, corresponds to one of the psychotherapeutic methods, only that on gaining a profounder insight into the neuroses we are not forced to limit ourselves to this consolation alone. We have developed the technique of hypnotic suggestion, of psychotherapy through diversion, through practice, and through the evocation of serviceable affects. I do not disdain any of them, and would practice them all under suitable conditions. That I have in reality restricted myself to a single therapeutic procedure, to the method called by Breuer "cathartic," which I prefer to call "analytic," is simply due to subjective motives which guided me. Having participated in the elaboration of this therapy I feel it a personal duty to devote myself to its investigation, and to the final development of its technique. I maintain that the analytic method of psychotherapy is one which acts most penetratingly, and carries farthest; through it one can produce the most prolific changes in the patient. If I relinquish for a moment the therapeutic point of view, I can assert that it is the most interesting, and that it alone teaches us something concerning the origin and the connection of the morbid manifestations. Owing to insights which it opens for us into the mechanism of the psychic malady, it can even lead us beyond itself, and show us the way to still other kinds of therapeutic influences.

Allow me now to correct some errors, and furnish some explanations concerning this cathartic or analytic method of psychotherapy.

(*a*) I notice that this method is often mistaken for the hyp-

notic suggestive treatment. I notice this by the fact that quite frequently colleagues whose confidant I am not by any means, send patients to me, refractory patients, of course, with the request that I should hypnotize them. Now, for eight years I have not practiced hypnotism (individual cases excluded) as a therapeutic aim, and hence I used to return the patients with the advice that he who relies on hypnosis should do it himself. In truth, the greatest possible contrast exist between the suggestive and the analytic technique, that contrast which the great Leonardo da Vinci has expressed for the arts in the formulæ per via di porre and per via di levare. Said Leonardo, "the art of painting works per via di porre, that is to say, places little heaps of paint where they have not been before on the uncolored canvas; sculpturing, on the other hand, goes per via di levare, that is to say, it takes away from the stone as much as covers the surface of the statue therein contained." Quite similarly, gentlemen, the suggestive technique acts per via di porre, it does not concern itself about the origin, force, and significance of the morbid symptoms, but puts on something, to wit, the suggestion which it expects will be strong enough to prevent the pathogenic idea from expression. On the other hand the analytic therapy does not wish to put on anything, or introduce anything new, but to take away, and extract, and for this purpose it concerns itself with the genesis of the morbid symptoms, and the psychic connection of the pathogenic idea the removal of which is its aim. This manner of investigation has considerably furthered our understanding. I have so early given up the technique of suggestion, and with it hypnosis, because I despaired of making the suggestion as strong and persistent as would be necessary for a lasting cure. In all grave cases I noticed that the suggestions which were put on crumbled off again, and then the disease, or one replacing it, reappeared. Besides, I charge this technique with concealing from us the psychic play of forces, for example, it does not permit us to recognize the resistance with which the patients adhere to their malady, with which they also strive against the recovery, and which alone can give us an understanding of their behavior in life.

(*b*) It seems to me that a very widespread mistake among my colleagues is the idea that the technique of the investigation for

the causes of the disease and the removal of the manifestations by this investigation is easy and self-evident. I concluded this from the fact that of the many who interest themselves in my therapy and express a definite opinion on the same, no one has yet asked me how I do it. There can only be one reason for it, they believe there is nothing to ask, that it is a matter of course. I occasionally also hear with surprise that in this or that division of the hospital a young interne is requested by his chief to undertake a "psychoanalysis" with a hysterical woman. I am convinced that he would not intrust him with the examination of an extirpated tumor without previously assuring himself that he is acquainted with the histological technique. Likewise I am informed that this or that colleague has made appointments with a patient for psychic treatment, whereas I am certain that he does not know the technique of such a treatment. He must, therefore, expect that the patient will bring him her secrets, or he seeks salvation in some kind of a confession or confidence. I should not wonder if the patient thus treated would rather be harmed than benefited. The mental instrument is really not at all easy to play. On such occasions I can not help but think of the speech of a world-renowned neurotic, who really never came under a doctor's treatment, and only lived in the fancy of the poet. I mean Prince Hamlet of Denmark. The king has sent the two couriers, Rosencrantz and Guildenstern, to investigate him and rob him of his secret. While he defended himself, pipes were brought on the stage. Hamlet took a pipe and requested one of his tormentors to play on it, saying that it is as easy to play as lying. The courtier hesitated because he knew no touch of it, and as he could not be moved to attempt to play the pipe, Hamlet finally burst forth: "Why, look you now, how unworthy a thing you make of me! You would play upon me; you would seem to know my stops; you would pluck out the heart of my mystery; you would sound me from my lowest note to the top of my compass; and there is much music, excellent voice, in this little organ, yet you cannot make it speak. 'Sblood! do you think I am easier to be played on than a pipe? Call me what instrument you will, though you can fret me, you cannot play upon me." (Act III, Scene 2.)

(*c*) You will have surmised from some of my observations

that the analytic cure contains qualities which keep it away from the ideal of a therapy. Tuto, cito, iucunde; the investigation and examination does not really mean rapidity of success, and the allusion to the resistance has prepared you for the expectation of inconveniences. Certainly the psychoanalytic method lays high claims on the patient as well as the physician. From the first it requires the sacrifice of perfect candor, it takes up much of his time, and is therefore also expensive; for the physician it also means the loss of much time, and due to the technique which he has to learn and practice, it is quite laborious. I even find it quite justified to employ more suitable remedies as long as there is a prospect to achieve something with them. It comes to this point only: if we gain by the more laborious and cumbersome procedure considerably more than by the short and easy one, the first is justified despite everything. Just think, gentlemen, by how much the Finsen therapy of lupus is more inconvenient and expensive than the formerly used cauterization and scraping, and yet it means a great progress, merely because it achieves more, it actually cures the lupus radically. I do not really wish to carry through the comparison, but psychoanalysis can claim for itself a similar privilege. In reality I could develop and test my therapeutic method in grave and in the gravest of cases only; my material at first consisted of patients who tried everything unsuccessfully, and had spent years in asylums. I hardly gained enough experience to be able to tell you how my therapy behaves in those lighter, episodically appearing diseases which we see cured under the most diverse influences, and also spontaneously. The psychoanalytic method was created for patients who are permanently incapacitated, and its triumph is to make a gratifying number of such, permanently capacitated. Against this success all expense is insignificant. We can not conceal from ourselves what we were wont to disavow to the patient, namely, that the significance of a grave neurosis for the individual subjected to it is not less than any cachexia or any of the generally feared maladies.

(*d*) In view of the many practical limitations which I have encountered in my work, I can hardly definitely enumerate the indications and contra-indications of this treatment. However, I will attempt to discuss with you a few points:

1. The former value of the person should not be overlooked in the disease, and you should refuse a patient who does not possess a certain degree of education, and whose character is not in a measure reliable. We must not forget that there are also healthy persons who are good for nothing, and that if they only show a mere touch of the neurosis, one is only too much inclined to blame the disease for incapacitating such inferior persons. I maintain that the neurosis does not in any way stamp its bearer as a dégéneré, but that frequently enough it is found in the same individual associated with the manifestations of degeneration. The analytic psychotherapy is therefore no procedure for the treatment of neuropathic degeneration, on the contrary it is limited by it. It is also not to be applied in persons who are not prompted by their own suffering to seek the treatment, but subject themselves to it by order of their relatives. The characteristic feature upon which the usefulness of the psychoanalytic treatment depends, the educability, we will still have to consider from another point of view.

2. If one wishes to take a safe course he should limit his selection to persons of a normal state, for, in psychoanalytic procedures, it is from the normal that we seize upon the morbid. Psychoses, confusional states, and marked (I might say toxic) depressions, are unsuitable for analysis, at least as it is practiced today. I do not think it at all impossible that with the proper changes in the procedure it will be possible to disregard this contraindication, and thus claim a psychotherapy for the psychoses.

3. The age of the patient also plays a part in the selection for the psychoanalytic treatment. Persons near or over the age of fifty lack, on the one hand, the plasticity of the psychic processes upon which the therapy depends—old people are no longer educable—and on the other hand, the material which has to be elaborated, and the duration of the treatment is immensely increased. The earliest age limit is to be individually determined; youthful persons, even before puberty, are excellent subjects for influence.

4. One should not attempt psychoanalysis when it is a question of rapidly removing a threatening manifestation, as, for example, in the case of an hysterical anorexia.

You have now gained the impression that the sphere of application of the analytic psychotherapy is a very limited one, for you really heard me enumerate nothing but contraindications. Nevertheless, there remain sufficient cases and morbid states, such as all chronic forms of hysteria with remnant manifestations, the extensive realm of compulsive states, abulias, etc., on which this therapy can be tried.

It is pleasing that particularly the worthiest and highest developed persons can thus be most helped. Where the analytic psychotherapy has accomplished but little one can cheerfully assert that any other treatment would have certainly resulted in nothing.

(*e*) You will surely wish to ask me about the possibility of doing harm through the application of psychoanalysis. To this I will reply that if you will judge justly you will meet this procedure with the same critical good-feeling as you have met our other therapeutic methods, and doing this you will have to agree with me that a rationally executed analytic treatment entails no dangers for the patient. One who, like a layman, is accustomed to ascribe to the treatment everything occurring during the disease, will probably judge differently. It is really not so long since our hydrotherapeutic asylums met with similar opposition. Thus one who was advised to go to such an asylum became thoughtful because he had an acquaintance who entered the asylum as nervous and there became insane. As you surmise we deal with cases of initial general paresis who in the first stages could still be sent to hydrotherapeutic asylums, and who there merged into the irresistible course leading to manifest insanity. For the layman the water was the cause and author of this sad transformation. Where it is a question of unfamiliar influences, even doctors are not free from such mistaken judgment. I recall having once attempted to treat a woman by psychotherapy who passed a great part of her existence by alternating between mania and melancholia. I began to treat her at the end of a melancholia and everything seemed to go well for two weeks, but in the third week she was again merging into a mania. It was surely a spontaneous alteration of the morbid picture, for two weeks is no time in which anything can be accomplished by psychotherapy, but the prominent—now deceased—physician who saw the case

with me could not refrain from remarking that this decline must have been due to the psychotherapy. I am quite convinced that he would have been more critical under different conditions.

(*f*) In conclusion, gentlemen, I must say to myself that it will not do to lay claim to your attention so long in favor of the analytic psychotherapy without telling you of what this treatment consists, and on what it is based. To be sure I can only indicate it as I have to be brief. This therapy is founded on the understanding that unconscious ideas—or rather the unconsciousness of certain psychic processes—are the main causes of a morbid symptom. We share this conviction with the French school (Janet) which moreover by gross schematization reduces the hysterical symptom to an unconscious idée fixe. Do not fear now that we will thus merge too far into the obscurest philosophy. Our unconscious is not quite the same as that of the philosophers and what is more, most philosophers wish to know nothing of the "psychical unconscious." But if you will put yourselves in our position, you will understand that the interpretation of this unconscious, in patients' psychic life, into the conscious, must result in a correction of their deviation from the normal, and in an abrogation of the compulsion controlling their psychic life. For the conscious will reaches as far as the conscious psychic processes and every psychic compulsion is substantiated by the unconscious. You need never fear that the patient will be harmed by the emotion produced in the entrance of his unconscious into consciousness, for you can theoretically readily understand that the somatic and affective activity of the emotion which became conscious can never become as great as those of the unconscious. For we only control all our emotions by directing upon them our highest psychic activities which are connected with consciousness.

We can still choose another point of view for the understanding of the psychoanalytic treatment. The revealing and interpreting of the unconscious takes place under constant resistance on the part of the patient. The emerging of the unconscious is connected with displeasure and owing to this displeasure it is continuously repulsed by the patient. It is upon this conflict in the patient's psychic life that you encroach, and if you succeed in prevailing upon him to accept something, for motives of better

insight, which he has thus far repulsed (repressed) on account of the automatic adjustment of displeasure, you have achieved in him a piece of educational work. For it is really an education if you can induce a person to leave his bed early in the morning despite his unwillingness to do so. As such an after training for the overcoming of inner resistances you can conceive the psychoanalytic treatment in quite a general manner. But in no sphere of the nervous patients is such an after training so essential as in the psychic elements of their sexual life. For nowhere have culture and education produced as much harm as here, and it is here, as experience will show you, that the controlling etiologies of the neuroses are found. The other etiological element, the constitutional contribution, is really given to us as something immutable. But this gives rise to an important demand on the doctor. Not only must he be of unblemished character—"morality is really a matter of course" as the principal person in Th. Vischer's "Auch Einer" used to say—but he must have overcome in his own personality the mixture of lewdness and prudishness with which so many others are wont to meet the sexual problems.

This is perhaps the place for another observation. I know that the emphasis which I laid on the sexual rôle in the origin of the psychoneuroses has become widely known. But I also know that restriction and nearer determinations are of little use with the great public; the multitude has little room in its memory, and generally retains from a statement the bare nucleus, thus creating for itself an easily remembered extreme. The same might also have happened to some physicians when the faint notion that they have of my theory is that I trace back the neurosis in the last place to sexual privation. Of such there is surely no dearth under the vital conditions of our society. But if that supposition were true would it not seem obvious that in order to avoid the roundabout way of the psychic treatment and tend directly towards the cure, we should directly recommend sexual participation as the remedy? I really do not know what could induce me to suppress these conclusions if they were justified. But the state of affairs is different. The sexual need or privation is merely one of the factors playing a part in the mechanism of the neurosis, and if it alone existed the result would not be a disease but a

dissipation. The other equally indispensable factor, which one is only too ready to forget, is the sexual repugnance of neurotics, their inability to love; it is that psychic feature which I have designated as "repression." It is only from the conflict between the two strivings that the neurotic malady originates, and it is for this reason that the advice for sexual participation in the psychoneuroses can really only seldom be designated as good.

Allow me to conclude with this guarded remark. Let us hope that with an interest for psychotherapy, purified of all hostile prejudice, you will help us to do some good in the treatment of the severe cases of psychoneuroses.

CHAPTER IX.

MY VIEWS ON THE RÔLE OF SEXUALITY IN THE ETIOLOGY OF THE NEUROSES.[1]

I am of the opinion that my theory on the etiological significance of the sexual moment in the neuroses can be best appreciated by following its development. I will by no means make any effort to deny that it passed through an evolution during which it underwent a change. My colleagues can find the assurance in this admission that this theory is nothing other than the result of continued and painstaking experiences. In contradistinction to this whatever originates from speculation can certainly appear complete at one go and continue unchanged.

Originally the theory had reference only to the morbid pictures comprehended as "neurasthenia," among which I found two types which occasionally appeared pure, and which I described as "actual neurasthenia" and "anxiety neurosis." For it was always known that sexual moments could play a part in the causation of these forms, but they were found neither regularly effective, nor did one think of conceding to them a precedence over other etiological influences. I was above all surprised at the frequency of coarse disturbances in the vita sexualis of nervous patients. The more I was in quest of such disturbances, during which I remembered that all men conceal the truth in things sexual, and the more skillful I became in continuing the examination despite the incipient negation, the more regularly such disease-forming moments were discovered in the sexual life, until it seemed to me that they were but little short of universal. But one must from the first be prepared for similar frequent occurrences of sexual irregularities under the stress of the social relations of our society, and one could therefore remain in doubt as to what part of the deviation from the normal sexual function is to be considered as a morbid cause. I could therefore only place less value on the regular demonstration of sexual noxas than on other experiences which appeared to me to be less equivocal.

[1] From Löwenfeld, "Sexualleben und Nervenleiden," IV ed., 1906.

It was found that the form of the malady, be it neurasthenia or anxiety neurosis, shows a constant relation to the form of the sexual injury. In the typical cases of neurasthenia we could always demonstrate masturbation or accumulated pollutions, while in anxiety neurosis we could find such factors as coitus interruptus, "frustrated excitement," etc. The moment of insufficient discharge of the generated libido seemed to be common to both. Only after this experience, which is easy to gain and very often confirmed, had I the courage to claim for the sexual influences a prominent place in the etiology of the neurosis. It also happened that the mixed forms of neurasthenia and anxiety neurosis occurring so often, showed the admixture of the etiologies accepted for both, and that such a bipartition in the form of the manifestations of the neurosis seemed to accord well with the polar characters of sexuality (male and female).

At the same time, while I assigned to sexuality this significance in the origin of the simple neurosis, I still professed for the psychoneuroses (hysteria and obsessions) a purely psychological theory in which the sexual moment was no differently considered than any other emotional sources. Together with J. Breuer, and in addition to observations which he has made on his hysterical patients fully a decade before I have studied the mechanism of the origin of hysterical symptoms by the awakening of memories in hypnotic states. We obtained information which permitted us to cross the bridge from Charcot's traumatic hysteria to the common non-traumatic hysteria. We reached the conception that the hysterical symptoms are permanent results of psychic traumas, and that the amount of affect belonging to them was pushed away from conscious elaboration by special determinations, thus forcing an abnormal road into bodily innervation. The terms "strangulated affect," "conversion," and "ab-reaction," comprise the distinctive characteristics of this conception.

In the close relations of the psychoneuroses to the simple neuroses, which can go so far that the diagnostic distinction is not always easy for the unpracticed, it could happen that the cognition gained from one sphere has also taken effect in the other. Leaving such influences out of the question, the deep study of the psychic traumas also leads to the same results. If by the "analytic" method we continue to trace the psychic

traumas from which the hysterical symptoms are derived, we finally reach to experiences which belong to the patient's childhood, and concerns his sexual life. This can be found even in such cases where a banal emotion of a non-sexual nature has occasioned the outburst of the disease. Without taking into account these sexual traumas of childhood we could neither explain the symptoms, find their determination intelligible, nor guard against their recurrence. The incomparable significance of sexual experiences in the etiology of the psychoneuroses seems therefore firmly established, and this fact remains until today one of the main supports of the theory.

If we represent this theory by saying that the course of the life long hysterical neurosis lies in the sexual experiences of early childhood which are usually trivial in themselves, it surely would sound strange enough. But if we take cognizance of the historical development of the theory, and transfer the main content of the same into the sentence: hysteria is the expression of a special behavior of the sexual function of the individual, and that this behavior was already decisively determined by the first effective influences and experiences of childhood, we will perhaps be poorer in a paradox but richer in a motive for directing our attention to a higherto very neglected and most significant after-effect of infantile impressions in general.

As I reserve the question whether the etiology of hysteria (and compulsion neurosis) is to be found in the sexual infantile experiences for a later more thorough discussion, I now return to the construction of the theory expressed in some small preliminary publications in the years 1895–1896.[2] The bringing into prominence of the assumed etiological moments permitted us at the time to contrast the common neuroses which are maladies with an actual etiology, with the psychoneuroses which etiology was in the first place to be sought in the sexual experiences of remote times. The theory culminates in the sentence: In a normal vita sexualis no neurosis is possible.

If I still consider today this sentence as correct it is really not surprising that after ten years labor on the knowledge of these relations I passed a good way beyond my former point of

[2] See Chapter VII, and Zur Aetiologie der Hysterie, Wiener, Klinische Rundschau, 1896.

view, and that I now think myself in a position to correct by detailed experience the imperfections, the displacements, and the misconceptions, from which this theory then suffered. By chance my former rather meagre material furnished me with a great number of cases in which infantile histories, sexual seduction by grown-up persons or older children, played the main rôle. I overestimated the frequency of these (otherwise not to be doubted) occurrences, the more so because I was then in no position to distinguish definitely the deceptive memories of hysterical patients concerning their childhood, from the traces of the real processes, whereas, I have since then learned to explain many a seduction fancy as an attempt at defense against the reminiscences of their own sexual activity (infantile masturbation). The emphasis laid on the "traumatic" element of the infantile sexual experience disappeared with this explanation, and it remained obvious that the infantile sexual activities (be they spontaneous or provoked) dictate the course of the later sexual life after maturity. The same explanation which really corrects the most significant of my original errors perforce also changed the conception of the mechanism of the hysterical symptoms. These no longer appeared as direct descendants of repressed memories of sexual infantile experiences, but between the symptoms and the infantile impressions there slipped in the fancies (confabulations of memory) of the patients which were mostly produced during the years of puberty and which on the one hand, are raised from and over the infantile memories, and on the other, are immediately transformed into symptoms. Only after the introduction of the element of hysterical fancies did the structure of the neurosis and its relation to the life of the patient become transparent. It also resulted in a veritable surprising analogy between these unconscious hysterical fancies and the romances which became conscious as delusions in paranoia.

After this correction the "infantile sexual traumas" were in a sense supplanted by the "infantilism of sexuality." A second modification of the original theory was not remote. With the accepted frequency of seduction in childhood there also disappeared the enormous emphasis of the accidental influences of sexuality to which I wished to shift the main rôle in the causation of the disease without, however, denying constitutional and heredi-

tary moments. I even hoped to solve thereby the problem of the selection of the neurosis, that is, to decide by the details of the sexual infantile experience, the form of the psychoneurosis into which the patient may merge. Though with reserve I thought at that time that passive behavior during these scenes results in the specific predisposition for hysteria, while active behavior results in compulsion neurosis. This conception I was later obliged to disclaim completely though some facts of the supposed connection between passivity and hysteria, and activity and compulsion neurosis, can be maintained to some extent. With the disappearance of the accidental influences of experiences, the elements of constitution and heredity had to regain the upper hand, but differing from the view generally in vogue I placed the "sexual constitution" in place of the general neuropathic predisposition. In my recent work, "Three Contributions to the Sexual Theory,"[3] I have attempted to discuss the varieties of this sexual constitution, the components of the sexual impulse in general, and its origin from the contributory sources of the organism.

Still in connection with the changed conception of the "sexual infantile traumas," the theory continued to develop in a course which was already indicated in the publications of 1894–1896. Even before sexuality was installed in its proper place in the etiology, I had already stated as a condition for the pathogenic efficaciousness of an experience that the latter must appear to the ego as unbearable and thus evoke an exertion for defense. To this defense I have traced the psychic splitting—or as it was then called the splitting of consciousness—of hysteria. If the defense succeeded, the unbearable experience with its resulting affect was expelled from consciousness and memory; but under certain conditions the thing expelled which was now unconscious, developed its activity, and with the aid of the symptoms and their adhering affect it returned into consciousness, so that the disease corresponded to a failure of the defense. This conception had the merit of entering into the play of the psychic forces, and hence approximate the psychic processes of hysteria to the normal instead of shifting the characteristic of the neurosis into an enigmatic and no further analyzable disturbance.

Further inquiries among persons who remained normal furnished

[3] Trans. by A. A. Brill, Journal of Nervous & Mental Disease Monograph Series.

the unexpected result, that the sexual histories of their childhood need not differ essentially from the infantile life of neurotics, and that especially the rôle of seduction is the same in the former, so the accidental influences receded still more in comparison to the moments of "repression" (which I began to use instead of "defense"). It really does not depend on the sexual excitements which an individual experiences in his childhood but above all on his reactions towards these experiences, and whether these impressions responded with "repression" or not. It could be shown that spontaneous sexual manifestations of childhood were frequently interrupted in the course of development by an act of repression. The sexual maturity of neurotic individuals thus regularly brings with it a fragment of "sexual repression" from childhood which manifests itself in the requirements of real life. Psychoanalysis of hysterical individuals show that the malady is the result of the conflict between the libido and the sexual repression, and that their symptoms have the value of a compromise between both psychic streams.

Without a comprehensive discussion of my conception of repression I could not explain any further this part of the theory. It suffices to refer here to my "Three Contributions to the Sexual Theory," where I have made an attempt to throw some light on the somatic processes in which the essence of sexuality is to be sought. I have stated there that the constitutional sexual predisposition of the child is more irregularly multifarious than one would expect, that it deserves to be called "polymorphous-perverse," and that from this predisposition the so called normal behavior of the sexual functions results through a repression of certain components. By referring to the infantile character of sexuality, I could form a simple connection among normal, perversions, and neurosis. The normal resulted through the repression of certain partial impulses and components of the infantile predisposition, and through the subordination of the rest under the primacy of the genital zones for the service of the function of procreation. The perversions corresponded to disturbances of this connection due to a superior compulsive-like development of some of the partial impulses, while the neurosis could be traced to a marked repression of the libidinous strivings. As almost all perversive impulses of the infantile predisposition are demon-

strable as forces of symptom formation in the neurosis, in which, however, they exist in a state of repression, I could designate the neurosis as the "negative" of the perversion.

I think it worth emphasizing that with all changes my ideas on the etiology of the psychoneuroses still never disavowed or abandoned two points of view, to wit, the estimation of sexuality and infantilism. In other respects we have in place of the accidental influences the constitutional moments, and instead of the pure psychologically intended defense we have the organic "sexual repression." Should anybody ask where a cogent proof can be found for the asserted etiological significance of sexual factors in the psychoneuroses, and argue that since an outburst of these diseases can result from the most banal emotions, and even from somatic causes, a specific etiology in the form of special experiences of childhood must therefore be disavowed; I mention as an answer for all these arguments the psychoanalytic investigation of neurotics as the source from which the disputed conviction emanates. If one only makes use of this method of investigation he will discover that the symptoms represent the whole or a partial sexual manifestation of the patient from the sources of the normal or perverse partial impulses of sexuality. Not only does a good part of the hysterical symptomatology originate directly from the manifestations of the sexual excitement, not only are a series of erogenous zones in strengthening infantile attributes raised in the neurosis to the importance of genitals, but even the most complicated symptoms become revealed as the converted representations of fancies having a sexual situation as a content. He who can interpret the language of hysteria can understand that the neurosis only deals with the repressed sexuality. One should, however, understand the sexual function in its proper sphere as circumscribed by the infantile predisposition. Where a banal emotion has to be added to the causation of the disease, the analysis regularly shows that the sexual components of the traumatic experience, which are never missing, have exercised the pathogenic effect.

We have unexpectedly advanced from the question of the causation of the psychoneuroses to the problem of its essence. If we wish to take cognizance of what we discovered by psychoanalysis we can ouly say that the essence of these maladies lies in disturb-

ances of the sexual processes, in those processes in the organism which determine the formation and utilization of the sexual libido. We can hardly avoid perceiving these processes in the last place as chemical, so that we can recognize in the so-called actual neuroses the somatic effects of disturbances in the sexual metabolism, while in the psychoneuroses we recognize besides the psychic effects of the same disturbances. The resemblance of the neuroses to the manifestations of intoxication and abstinence following certain alkaloids, and to Basedow's and Addison's diseases, obtrudes itself clinically without any further ado, and just as these two diseases should no more be described as "nervous diseases," so will the genuine "neuroses" soon have to be removed from this class despite their nomenclature.

Everything that can exert harmful influences in the processes serving the sexual function therefore belongs to the etiology of the neurosis. In the first place we have the noxas directly affecting the sexual functions insofar as they are accepted as injuries by the sexual constitution which is changeable through culture and breeding. In the second place, we have all the different noxas and traumas which may also injure the sexual processes by injuring the organism as a whole. But we must not forget that the etiological problem in the neuroses is at least as complicated as in the causation of any other disease. One single pathogenic influence almost never suffices, it mostly requires a multiplicity of etiological moments reinforcing one another, and which can not be brought in contrast to one another. It is for that reason that the state of neurotic illness is not sharply separated from the normal. The disease is the result of a summation, and the measure of the etiological determinations can be completed from any one part. To seek the etiology of the neurosis exclusively in heredity or in the constitution would be no less one sided than to attempt to raise to the etiology the accidental influences of sexuality alone, even though the explanations show that the essence of this malady lies only in a disturbance of the sexual processes of the organism.

CHAPTER X.

Hysterical Fancies and their Relations to Bisexuality.[1]

The delusional formations of paranoiacs containing the greatness and sufferings of their own ego, which manifest themselves quite typically in almost monotonous forms are universally familiar. Furthermore, through numerous communications we became acquainted with the peculiar organizations by means of which certain perverts put into operation their sexual gratifications, be it in fancy or reality. On the other hand it may sound rather novel to some to hear that quite analogous psychic formations regularly appear in all psychoneuroses, especially in hysteria, and that these so called hysterical fancies show important relations to the causation of the neurotic symptoms.

Of the same source and of the normal prototype are all these fantastic creations, so called reveries of youth, which have already gained a certain consideration in the literature, though not a sufficient one.[2] They are perhaps equally frequent in both sexes; in girls and women they seem to be wholly of an erotic nature, while in men they are of an erotic or ambitious nature. Yet even in men the significance of the erotic moment is not to be put in the second place, for one examining more closely the reveries of men we generally learn that all these heroic acts are accomplished, that all these successes are acquired in order to please a woman and to be preferred to other men.[3] These fancies are wish gratifications which emanate from privation and longing. They are justly named "day dreams" for they give the key for the under-

[1] Zeitschrift für Sexualwissenschaft, herausgegeben von Hirschfeld, I, 1908.

[2] Compare Breuer and Freud, Studien über Hysterie, 1895. P. Janet, Névroses et ideés fixes, I (Les rêveries subconscientes), 1898. Havelock Ellis, Sexual Impulse and Modesty (German by Kötscher), 1900. Freud, Traumdeutung, 1906, 2d ed., 1909. A. Pick, Über pathologische Träumerei und ihre Beziehungen zur Hysteria, Jahrbuch für Psychiatrie und Neurologie, XIV, 1896.

[3] H. Ellis similarly expresses himself, l. c., p. 185.

standing of night dreams in which the nucleus of the dream formation is produced by just such complicated, disfigured day fancies which are misunderstood by the conscious psychic judgment.[4]

These day dreams are garnished with great interest, are cautiously nurtured, and coyly guarded, as if they were numbered among the most intimate estates of personality. On the street however, the day dreamer can be readily recognized by a sudden, as if absent-minded smile, by talking to himself, or by a running-like acceleration of his gait wherein he designates the acme of the imaginary situation.

All hysterical attacks which I have been thus far able to examine proved to be such involuntary incursions of day dreams. Observation leaves no doubt that such fancies may exist as unconscious or conscious and whenever they become unconscious they may also become pathogenic, that is, they may express themselves in symptoms and attacks. Under favorable conditions it is possible for consciousness to seize such unconscious fancies. One of my patients whose attention I have called to her fancies narrated that once while in the street she suddenly found herself in tears, and rapidly reflecting over the cause of her weeping the fancy became clear to her. She fancied herself in delicate relationship with a piano virtuoso familiar in the city, but whom she did not know personally. In her fancy she bore him a child (she was childless), and he then deserted her, leaving her and her child in misery. At this passage of the romance she burst into tears.

The unconscious fancies are either from the first unconscious, having been formed in the unconscious, or what is more frequently the case they were once conscious fancies, day dreams, and were then intentionally forgotten, merging into the unconscious by "repression." Their content then either remained the same or underwent a transformation, so that the present unconscious fancy represents a descendant of the once conscious one. The unconscious fancy stands in a very important relation to the sexual life of the person, it is really identical with that fancy which helped it towards sexual gratification during a period of masturbation. The masturbating act (in the broader sense the onanistic) then consisted of two parts, the evocation of the fancy,

[4] Compare Freud, The Interpretation of Dreams, translated by A. A. Brill, The Macmillan Co., New York, and George Allen Co., London.

and the active performance of self gratification at the height of the same. This combination is familiarly in itself a soldering.[5] Originally this action was a purely auto-erotic undertaking for the pleasure obtained from a certain so called erogenous part of the body. Later this action blended with a wish presentation from the sphere of the object loved, and served for a partial realization of the situation in which this fancy culminated. If, then, the person forgoes in this manner the masturbo-fantastic gratification, the action remains undone, the fancy, however, changes from a conscious to an unconscious one. If no other manner of sexual gratification occurs, if the person remains abstinent and does not succeed in sublimating his libido, that is, in diverting the sexual excitement to a higher aim, we then have the conditions for the refreshment of the unconscious fancy; it grows exuberantly and with all the force of the desire for love at least a fragment of its content becomes a morbid symptom.

The unconscious fancies are then the nearest psychical first steps of a whole series of hysterical symptoms. The hysterical symptoms are nothing other than unconscious fancies brought to light by "conversion," and insofar as they are somatic symptoms they are frequently enough taken from the spheres of the sexual feelings and motor innervations which originally accompanied the former still conscious fancies. In this way the disuse of onanism is really made retrograde, and the final aim of the whole pathological process, the restoration of the primary sexual gratification, though it never becomes perfect, in a manner always achieves a certain approximation.

The interest of him who studies hysteria turns directly from the symptoms to the fancies from which the former originate. The technique of psychoanalysis gives the means of finding out from the symptoms other unconscious fancies, and then of bringing them back to the patient's consciousness. In this way it was found that the unconscious fancies of hysterics perfectly correspond in content to the consciously performed gratification situations of perverts. Those who lack examples of such nature need only recall the historical managements of the Roman Caesars whose frenzies were naturally only conditioned by the unrestricted fullness of the fancy creators. The delusional formations of

[5] Compare Freud, Three Contributions to the Sexual Theory, Monograph Series.

paranoiacs are of the same nature, they are fancies which directly become conscious, and which are borne by the masochistic-sadistic components of the sexual impulse. Complete counterparts of these can also be found in certain unconscious fancies of hysterics. It is a familiar, practically significant fact that hysterics express their fancies not as symptoms but in conscious realization, and in this way they feign and commit murders, assaults, and sexual aggressions.

All that can be found out about the sexuality of the psychoneurotic can be ascertained by the psychoanalytic examination which leads from the obtrusive symptoms to the hidden unconscious fancies; herein, too, is the fact, the communication of which will be put in the foreground of this short preliminary publication.

Probably in view of the difficulties which prevent the effort of the unconscious fancies from expressing themselves, the relation between the fancies to the symptoms is not simple but rather manifoldly complicated.[6] As a rule, that is, in a fully developed and a long standing neurosis, a symptom does not correspond to an individual unconscious fancy, but to a number of such, and indeed it is not arbitrary but in lawful combination. To be sure in the beginning of the disease all these complications are not developed.

For the sake of general interest I pass over the connection of this communication and insert a series of formulæ which strive to progressively exhaust the nature of hysteria. They do not contradict one another but correspond partly to more complete and sharper conceptions, and partly to the use of different points of view.

1. The hysterical symptom is the memory symbol of certain efficacious (traumatic) impressions and experiences.

2. The hysterical symptom is the compensation by conversion for the associative return of the traumatic experience.

3. The hysterical symptom—like all other psychic formations—is the expression of a wish realization.

4. The hysterical symptom is the realization of an unconscious fancy serving as a wish fulfillment.

[6] The same thing holds true for the relation between the "latent" thoughts of the dream and the elements of the manifest content of the dream. See the Chapter on the "Dream Work" in the author's Interpretation of Dreams.

5. The hysterical symptom serves as a sexual gratification, and represents a part of the sexual life of the individual (corresponding to one of the components of his sexual impulse).

6. The hysterical symptom, in a fashion, corresponds to the return of the sexual gratification which was real in infantile life but had been repressed since then.

7. The hysterical symptom results as a compromise between two opposing affects or impulse incitements, one of which strives to bring to realization a partial impulse, or a component of the sexual constitution, while the other strives to suppress the same.

8. The hysterical symptom may undertake the representation of diverse unconscious non sexual incitements, but can not lack the sexual significance.

It is the seventh among these determinations which expresses most exhaustively the essence of the hysterical symptom as a realization of an unconscious fancy, and it is the eighth which properly designates the significance of the sexual moment. Some of the preceding formulæ are contained as first steps in this formula.

In view of these relations between symptoms and fancies one can readily reach from the psychoanalysis of the symptoms to the knowledge of the components of the sexual impulse controlling the individual, just as I have shown in the "Three Contributions to the Sexual Theory." But in some cases this examination gives rather unexpected results. It shows that many symptoms can not be solved by one unconscious sexual fancy or by a series of fancies in which the most significant and most primitive is of a sexual nature, but in order to solve the symptom two sexual fancies are required, one of the masculine and one of the feminine character, so that one of these fancies arises from a homosexual impulse. The axiom pronounced in formula seven is in no way effected by this novelty, so that a hysterical symptom necessarily corresponds to a compromise between a libidinous and a repressed emotion, but besides that, it can correspond to a union of two libidinous fancies of contrary sex characters.

I refrain from giving examples for this axiom. Experience has taught me that short analyses compressed into the form of an abstract can never make the demonstrable impression for which they were intended. The communication of fully analyzed cases must be reserved for another place.

I therefore content myself in formulating the axiom and in elucidating its significance:

9. An hysterical symptom is the expression, on the one hand, of a masculine, and on the other hand of a feminine unconscious sexual fancy.

I expressly observe that I am unable to adjudge to this axiom the similar general validity that I claimed for the other formulæ. As far as I can see it is met neither in all symptoms of a single case, nor in all cases. On the contrary it is not difficult to find cases in which the contrary sexual emotions have found separate symptomatic expression, so that the symptoms of hetero- and homosexuality can be as sharply distinguished from each other as the fancies hidden behind them. Nevertheless, the relation claimed in the ninth formula occurs frequently enough, and wherever it is found it is of sufficient significance to merit a special formulation. It seems to me to signify the highest stage of complexity to which the determination of hysterical symptoms can reach, and can only be expected in a long standing neurosis and where a great amount of organization has occurred.[7]

The demonstrable bisexual significance of hysterical symptoms occurring in many cases is indeed an interesting proof for the assertion formulated by me that the supposed bisexual predisposition of man can be especially recognized in psychoneurotics by means of psychoanalysis.[8] Quite an analogous process from the same sphere is that in which the masturbator in his conscious fancies attempts to live through in his imagination the fancied situations of both the man and the woman. Other counterparts are found in certain hysterical crises in which the patients play both rôles lying at the basis of sexual fancies; thus, for example, one of the cases under my observation presses his garments to his body with one arm (as woman), and with the other arm he attempts to tear them off (as man). This contradictory simultaneity determines most of the incomprehensibility of the situation otherwise so plastically represented in the attack, and is ex-

[7] Indeed J. Sadger, who recently discovered this sentence in question, independently by psychoanalysis, claims for it a general validity (Die Bedeutung der psychoanalytische Methode nach Freud, Zentralbl. f. Nerv. u. Psych., Nr. 229).

[8] Three Contributions to the Sexual Theory.

cellently suited for the concealment of the effective unconscious fancy.

In psychoanalytical treatment it is very important to be prepared for the bisexual significance of a symptom. It should not be at all surprising or misleading when a symptom remains apparently undiminished in spite of the fact that one of its sexual determinants is already solved. Perhaps it is still supported by the unsuspected contrary sexual. Furthermore during the treatment of such cases we can observe how the patient makes use of this convenience. During the analysis of the one sexual significance he continually switches his thoughts into the sphere of the contrary significance just as if onto a neighboring track.

CHAPTER XI.

Concerning "Wild" Psychoanalysis.

During my consultation hours some days ago an elderly woman called on me accompanied by a protecting friend and complained of states of anxiety. She was in the latter half of her fortieth year, quite well preserved and seemingly had not yet reached her menopause. The separation from her last husband was supposed to have been the cause of her disease, but according to her statement the anxiety had considerably increased since she had consulted a young physician in her suburban town. He explained to her that the cause of her anxiety lay in her sexual demands; that she could not dispense with sexual relations and that for that reason she had only three roads to health—either to return to her husband, to take a lover or to gratify herself. Since that time she became convinced that she was incurable as she did not wish to return to her husband and her moral and religious feelings were against the other two measures. She came to me because the physician had told her that this was a new viewpoint for which I was responsible and urged her to come to me for corroboration of the definite assertions. Her friend, a still older, embittered and unhealthy looking woman, then adjured me to assure the patient that this physician had been mistaken. She insisted that his statement could not be true for she herself had been a widow for many years and remained respectable without suffering from states of anxiety.

I shall not dwell upon the delicate situation into which I was placed by this visit but I shall explain the conduct of the colleague who had sent me this patient. First, I wish to advise caution which is perhaps—or let us hope—not superfluous. Experience of many years has taught me—as it could teach everyone else—not to accept readily as true that which patients, particularly nervous ones, relate in regard to their physician. No matter what the treatment is the neurologist not only becomes the target for the manifold hostile feelings of the patient, but through a form of

projection he must also occasionally be willing to assume responsibility for the patient's secret repressed wishes and it is a sad but significant fact that such thrusts find nowhere more ready credence than among other physicians.

I have, therefore, the right to hope that during the consultation the woman had given me a purposive distorted report of her physician's utterances and that I would be doing an injustice to one who was unknown to me if I based my observations concerning "wild" psychoanalysis on this particular case. However, in doing this I may be able to restrain others from doing injustice to their patients.

Let us therefore assume that the physician advised exactly what the patient reported. Everyone will then justly criticize that when a physician finds it necessary to discuss the theme of sexuality with a woman he should do it with tact and delicacy. However, these requirements are only a part of certain technical rules of psychoanalysis. Besides the physician has misconstrued or misunderstood a number of scientific theories of psychoanalysis and thereby proven how little he has advanced towards the understanding of its essentials and objects.

Let us begin with the latter—the scientific errors. The physician's advice clearly shows in what sense he grasps the "sexual life." He grasps it in the popular sense—namely, that under sexual demands nothing else is understood except the need for coitus or its analogy, the processes causing the orgasm or the ejaculation of the sexual product. But it could not have remained unknown to the physician that psychoanalysis was wont to be reproached for extending the idea of the sexual far beyond its usual limits. The fact is correct, though whether it is just to apply it as a reproach will not be discussed here. In psychoanalysis the idea of the sexual has a much greater compass; both above and below it far exceeds the popular sense. This extension justifies itself genetically; we also ascribe to the "sexual life" all manifestations of tender feelings which originated from the source of primitive sexual emotions, even if those emotions experience inhibition in their original sexual aim or have substituted this aim by another no longer sexual. We, therefore, also prefer to speak of psychosexuality, thus laying stress on the fact that the psychic factor of the sexual life should neither be over-

looked nor underestimated. We use the word "sexuality" in the same broad sense as the word "love" in the English language. We have also known for a long time that lack of psychic gratification with all its consequences may exist where there is no lack of normal sexual intercourse, and as therapeutists we always remember that only a small proportion of the ungratified sexual strivings whose substitutive gratification in the form of nervous symptoms we are trying to combat, can be done away with through coitus and other sexual acts.

Whoever does not share this conception of psychosexuality has no right to refer to the doctrines of psychoanalysis in which the etiological meaning of sexuality is dealt with. To be sure he has simplified the problem for himself by the exclusive emphasis of the somatic factor of sexuality, but he alone should be responsible for his action.

Still a second and equally serious misunderstanding is obvious from the advice of the physician.

It is true that psychoanalysis specifies that the lack of sexual gratification is the cause of nervous affliction, but does it not say more? Should one leave aside as too complicated the fact that it teaches that nervous symptoms result from a conflict between two forces, a libido (mostly of excessive growth), and an all too strong sexual rejection or repression? Whoever does not forget the second factor, which was not actually assigned to second rank, can never believe that sexual gratification as such is a universally reliable remedy for the complaints of the neurotic. A great many of these persons are incapable of obtaining gratification under the given conditions or under any conditions. If they were capable of it and had they not their inner resistances the force of the impulse would point out the way to gratification, even without the advice of the physician. What then is the use of such advice as the physician ostensibly gave this woman?

Even if it were justified scientifically it would nevertheless be unfeasible for her. If she had no inner resistances against onanism or against an intrigue she would long since have grasped one of these means. Or does the physician think that a woman of over forty years knows nothing of the possibility of taking a paramour, or does he so greatly overestimate his influence as to believe that without medical approval she could never decide on such a step?

All this seems very clear and still it must be admitted that there is one factor which often hinders the passing of sentence. Some of the nervous affections, the so-called actual neuroses, such as the typical neurasthenia and the pure anxiety neuroses, apparently depend on the somatic factor of the sexual life, while we have not yet any definite conception concerning the rôle played in them by the psychic factors and the repression. In such cases it is natural for the physician to have in view, first of all, an actual therapy, an alteration of the somatic sexual activity and he would be fully justified in so doing were his diagnosis correct. The woman who consulted this young physician complained above all of states of anxiety. He thus probably concluded that she was suffering from anxiety neurosis and felt justified in recommending her a somatic therapy. Again a convenient misunderstanding! He who suffers from anxiety does not necessarily have an anxiety neurosis. This diagnosis is not to be derived from the name. One must know what manifestations constitute anxiety neurosis and how to differentiate them from other morbid states which are also manifested through fear. According to my impression the woman in question suffered from an anxiety hysteria and the whole as well as the full value of such nosographic distinctions lies in the fact that they point to a different etiology and a different therapy. Whoever has in mind the possibility of such an anxiety hysteria would not have failed to neglect the psychic factors as shown in the alternative advice of the physician.

Strangely enough in the therapeutic alternative of this supposed psychoanalyst there is no place left for psychoanalysis. This woman could be freed of her anxiety only were she to return to her husband, or gratify herself by resorting to onanism, or to a paramour. And where would the analytical treatment enter which is the principal remedy in states of anxiety?

We thus come to the technical errors which we recognize in the procedure of the physician in the admitted case. It is easy to refer it to ignorance. It is a conception long since combated, based on a most superficial judgment, that the patient suffers from a lack of knowledge and when this ignorance is removed through enlightenment (concerning the causative relation of his illness with his life, regarding his childhood experiences, etc.) he must become well. It is not this lack of knowledge in itself that is the patho-

genic motive, but the determination of this ignorance by inner resistances which first called forth this ignorance and still supports it. The task of the therapy lies in the combating of these resistances. To impart that which the patient does not know because he has repressed it is only one of the necessary preparations for the therapy. If the knowledge of the unconscious were as important to the patient as the inexperienced psychoanalyst believes the cure would be effected if the patient attended lectures or read books on the subject. But these measures have just as much influence on the symptoms of nervous complaints as the distribution of menus has on hunger during a famine. The comparison is useful even beyond its original application, as the imparting of the unconscious to the patient regularly has the result of sharpening his conflict and of exaggerating his complaints.

But as the psychoanalysis cannot dispense with such information it dictates that it should be imparted only after the two following conditions have been fulfilled. First, after the patient has through preparation, himself come into the surrounding of his repression; and secondly, after he has become so attached to the physician (transference) that his feeling toward the latter would make the newer flight impossible.

Only through the fulfillment of these conditions does it become possible to recognize and master the resistances which have led to repression and ignorance. Hence a psychoanalytical procedure assumes from the beginning a longer contact with the patient; and attempts to surprise the patient by brusquely imparting to him his secrets guessed by the physician during his first consultation hour are technical errors which usually avenge themselves by the doctor's incurring the cordial enmity of the patient which thus cuts off every future influence.

We shall leave out of consideration the fact that one sometimes advises wrongly and that one is never in a position to guess everything. By the aid of these unequivocal technical rules psychoanalysis replaces the demand of the vague "medical tact" in which one looks for a special endowment.

It is therefore not enough that the physician should know some of the results of psychoanalysis, but he must also be well versed in its technique if he wishes to guide his medical actions by psychoanalytic viewpoints. This technique can not yet be learned

from books and to acquire it through one's self requires great sacrifices of time, effort and success. Like other medical techniques it is best learned from those who have already mastered it. It is therefore certainly not a matter of indifference for the criticism of the case on which I base my remarks, that I do not know nor have I ever heard the name of the physician who is supposed to have given such advice.

It is neither agreeable to me nor to my friends and coworkers to monopolize in such manner the claim to the practice of a medical technique. But in view of the dangers which may be anticipated from the practice of "wild" psychoanalysis for the patients as well as for the subject of psychoanalysis, no other course was left to us. In the spring of 1910 we founded an international psychoanalytic society, in order to be able to disclaim responsibility for the acts of all who do not belong to us and who call their medical practice "psychoanalysis." For as a matter of fact such wild analysts do more harm to the subject than to the individual patient. It has often been my experience that such an awkward procedure, even if it at first caused an aggravation of the symptoms, has nevertheless achieved a cure in the end. Not always, but quite often. After the patient has railed against the physician long enough and feels himself far enough removed from his influence his symptoms abate, or he decides to take a step which leads to the road of recovery. The final improvement is then supposed to have come "of itself," or is attributed to the most indifferent treatment of the physician who treated the patient last. As for the case of the women who complained against the physician we have heard, I should say that the wild psychoanalyst had nevertheless done more for his patient than any eminent authority who would have told her that she was suffering from a "vasomotor neurosis." He forced her attention to, or near, the real cause of her illness, and in spite of the patient's opposition this intervention will not remain without favorable results. He harmed himself, however, and helped to increase the prejudices against the activity of the psychoanalysts, which arise in the patients as a consequence of comprehensible affective resistances. And this can be avoided.

CHAPTER XII.

The Future Chances of Psychoanalytic Therapy.[1]

As the main object of this assemblage is for practical purposes, I will therefore take as my opening address a practical theme which will appeal not so much to your scientific as to your medical interest. I am indeed mindful of your judgment of the success of our therapy and I also take for granted that most of you have passed through the two initiative phases, to wit, the enthusiasm over the unexpected progress of our therapeutic accomplishment, and the depression over the enormous difficulties which stand in the way of our efforts. However, it really does not matter in what stage of this development some of you may be, I shall show today that we are by no means at the end of our therapeutic resources for combating the neuroses and that we have a right to expect a considerable improvement in our therapeutic chances in the future.

I believe that the reinforcement will come from three sides:

1. Through inner progress.
2. Through a gain in authority.
3. Through the general effect of our work.

By inner progress I understand the progress (*a*) in our analytic knowledge, (*b*) the progress in our technique.

(*a*) The progress in our knowledge: To be sure, we do not yet know everything that we need for the understanding of our patients' unconsciousness. It is therefore clear that any progress in our knowledge means additional strength for our therapy. As long as we did not understand anything we did not accomplish anything; and the more we shall learn to understand the more we shall accomplish. In the beginning, the psychoanalytic treatment was inexorable and inexhaustible. The patient had to tell everything himself, and the activity of the physician consisted in constantly urging him to continue. Today things look brighter. The treatment consists of two parts, of that which the physician dis-

[1] Lecture delivered before the second Psychoanalytic Congress at Nürnberg in 1910.

covers himself and tells the patient, and of the elaboration of that which he heard from the patient. For the mechanism of our treatment is really very easy to grasp. We give the patient the conscious expected ideas through the model of which he is enabled to find in himself the unconscious ones. This is the intellectual help which facilitates for him the overcoming of the resistance between the conscious and the unconscious. I also call your attention that this is not the only mechanism utilized in the analytic treatment; you are all acquainted with the more powerful mechanism lying in the utilization of the "transference." I shall endeavor in the future to deal with all these relationships which are important for the understanding of the treatment in a "General Method of Psychoanalysis." Nor is it necessary for me to reject your objection that in the present practice of our treatment the proof of the correctness of our assumption becomes obscured. You will not forget that these proofs are to be found elsewhere, and that a therapeutic encroachment cannot be conducted like a theoretical examination.

Allow me now to touch upon some spheres wherein we can learn something new and where we actually discover something new every day. The most prominent of these is the symbolism in the dream and in the unconscious. A theme forcibly contested, as you know! It is no small merit that our colleague, W. Stekel, has earned, when he devoted himself to dream symbolism, unconcerned about the protests raised by all the opponents. Here there is really much to be learned; my "Interpretation of Dreams" written in 1899 received important supplements from the study of symbols.

I should like to tell you something about one of these newly recognized symbols. Sometime ago I learned that a psychologist who is unfamiliar with our work remarked to one of my friends that we are surely overestimating the secret sexual significance of dreams. He stated that his most frequent dream was of climbing a stairway and that there was surely nothing sexual behind this. Our attention having been called to this objection, we directed our investigations to the occurrence of stairways, stairs, and ladders in the dream, and we soon ascertained that stairs (or anything analogous to them) represents a definite symbol of coitus. The basis for this comparison is not difficult to find. Under

rhythmic intervals and with increasing difficulty in breathing one reaches a height, and may come down again in a few rapid jumps. Thus the rhythm of coitus is recognizable in climbing stairs. Let us not forget to consider the usage of language. It shows us that the "climbing" or "mounting" is, without further addition, used as a substitutive designation of the sexual act. In French the step of the stair is called "la marche"; "un vieux marcheur" corresponds exactly to our "an old climber." Concerning another interesting symbol, the one of "rescuing" and its changed significance you will find a description in our publication.[2] But I am forced to stop here else I shall not come to the other points.

Everyone of you will convince himself from his own experience how different it is to face a new case after you have examined the structure of some typical case. Now suppose we could put together under a few formulæ the lawful in the structure of the neuroses, just as we succeeded in doing with the symptom formation of hysteria. How secured our prognostic judgment would thereby become! Indeed just as the obstetrician discovers from the inspection of the placenta whether it is completely expelled or whether harmful remnants are still left behind, so, independent of the result and the occasional state of the patient we could say whether we definitely succeeded in our work, or whether we must expect relapses or new symptoms.

(*b*) I hasten to the innovations in the technical spheres where the most part is still to be definitely confirmed, and where much is just now beginning to become clear. The psychoanalytic technique has now two objects in view, to save the physician effort, and to open to the patient the broadest avenue to his unconscious. You know that an important change has taken place in our technique. When we practised the cathartic treatment our aim was to explain the symptoms; next, we turned away from the symptoms, and aimed at the discovery of the "complexes"—a word that was made indispensable by Jung—; and now we turn our work directly to the discovery and the overcoming of the "resistances," justly trusting that the complexes will readily surrender with the recognition and the overcoming of the resistances. Some of you have since then shown a desire to look over and classify these resistances. I would therefore ask you to examine your

[2] Jahrbuch f. Psych., Vol. II.

material in order to find out whether you can confirm the following conection: The most important resistances to the treatment in male patients seem to emanate from the father complex, and are explained by the fear for the father, spite against, and disbelief in the father.

Other new discoveries in the technique concern the person of the physician himself. Our attention has been called to the "counter-transference" which ensues in the unconscious feelings of the physician through the influence of the patient, and we advise that the physician should recognize and overcome this counter-transference in himself. Ever since a large number of persons practicing psychoanalysis have exchanged ideas concerning their experiences, we have noticed that every psychoanalyst can only go so far with his patients as his own complexes and inner resistances allow. We therefore demand that he should begin his activity with a self-analysis which he should steadily deepen as he gains experience from his patients. He who does not achieve such self-analysis should without further ado give up the idea that he has the ability to treat patients analytically.

We are also beginning to realize that the analytic technique has to be subjected to certain modifications which depend upon the form of the disease and upon the predominant impulse of the patient. We have started with the therapy of conversion-hysteria; but we must slightly modify our procedure in anxiety-hysteria (phobias). For these patients cannot produce the final material for the solution of the phobia as long as they feel themselves protected by keeping the phobic determination. Of course nothing is attained from the fact that from the beginning of the treatment they waive the protective measures and labor under the determination of the anxiety. One must therefore continue to bring them help by translating for them their unconscious until they can make up their minds to waive the protection of the phobia and expose themselves to a very moderate fear. Only after this has been accomplished does the material become accessible, the control of which leads to the solution of the phobia. Other modifications of the technique which are not yet ripe for judgment are required in the treatment of the compulsion neuroses. Many important as yet unexplained questions arise in this connection; namely, to what extent may some gratification be allowed the combated

impulses of the patient during the treatment, and what difference it makes whether these impulses are of an active (sadistic) or passive (masochistic) nature.

I hope that you gained the impression that if we knew all which we are now only surmising, and if we will have brought about all the improvements in the technique to which the deeper experience of our patients must lead us, that our medical activity will then attain a precision and successful confidence not to be found in all special branches of medicine.

I said that we had much to expect from the gain in authority that must fall to our share in the course of time. There is no need for telling you much about the meaning of the authority. Only the smallest number of civilized people are able to exist without the support of others, or to pronounce an independent judgment. You cannot form too bad a conception of the mania for authority and of the inner instability of humanity. The extraordinary increase in the neuroses since the depotentialization of religion may furnish you with a standard for the same. The impoverishment of the ego through the great expenditure of repression which civilization demands of every individual may be one of the chief causes of this condition.

This authority and the enormous suggestion emanating from it was hitherto against us. All our therapeutic successes were aimed at this suggestion. It is really surprising that under such circumstances there were any successes at all. I will allow myself to go so far as to depict to you the delights of those times when I was the sole representative of psychoanalysis. I recall the patients who when assured that I could bring them lasting relief looked around my unpretentious surroundings and thought of my little reputation and title and then looked upon me as a possessor of a sure system of breaking a bank. They argued with themselves that if this man could do all he pretends he would look different. It was really not pleasant to perform a psychic operation while the colleague whose duty it should have been to assist took special pleasure in spitting into the field of operation, and while the relatives threatened the operator as soon as they noticed blood or the restless movements of the patient. Yet an operation should produce manifestations of reactions; in surgery we are long accustomed to it. They simply did not believe me,

just as today they still believe us very little; under such circumstances there had to be some failures. To form an estimate of the increase in our therapeutic chances if we gained general confidence, think of the position of the gynecologist in the Orient and in the Occident. All that the gynecologist is allowed to do in the Orient is done on the arm which is extended to him through a hole in the wall; he can only feel the pulse. But such an inaccessibility of the object is proportionate to the medical accomplishment. Our opponents in the Occident wish to allow us an almost similar disposition of the psyche of our patients. But since suggestion urged society to send the sick woman to the gynecologist the latter became the helper and saviour of the woman. Now do not say that if the authority of society came to our aid and considerably increased our successes, that this would still not prove the correctness of our assumptions. For suggestion can manifestly do everything, and our successes would then be considered successes of suggestion and not of psychoanalysis. Against this I can say that suggestion of society now favors hydro-, dietetic, and electro-therapy, and still these measures have not succeeded in combating the neuroses. It remains to be seen whether psychoanalytic treatment will be able to achieve more.

However, I must put a damper on your expectations. Society will not hasten to furnish us authority. Society must remain in a state of resistance towards us because we assume a critical attitude towards her. We inform her that she herself plays a great part in the causation of the neuroses. Just as we make an enemy of the individual by uncovering his repressions, so society cannot meet us with a sympathetic reply when we regardlessly lay bare her infirmities and inadequacies. Because we destroy illusions we are reproached for endangering ideals. It therefore seems that the condition through which I expect such great advance in our therapeutic chances will never come about. And still the situation is not as despairing as one would now think. As forcible as the interests and effects of humanity may be, there is still another force—the intellect. It does not gain authority in the beginning but is the more sure of it in the end. In the end the most cutting truths are heard and recognized especially after the injured interests and affects aroused by them have exhausted themselves. It was always so until now and the undesired truths

which we psychoanalysts have to tell the world will meet the same fate, only it will not come so rapidly; we must be able to wait.

I must finally explain what I mean by the "General Effects" of our work, and how I came to put hopes upon them. Here we meet with a very remarkable therapeutic constellation, the like of which is perhaps not to be found elsewhere. Until you will recognize in it something long familiar, it will at first appear strange to you. For you know that the psychoneuroses are distorted substitutive gratifications of impulses the existence of which one must deny to himself and to others. Their capacity to exist rests on this distortion and misjudgment. With the solution of the riddle they present and with the acceptance of this solution by the patients these morbid states become incapable of existence. There is hardly anything like it in medicine; in fairy tales you hear of evil spirits whose charm is broken as soon as one can tell them their secretly concealed name.

Now, instead of the individual patient, put all those suffering from neuroses,—society made up of healthy and abnormal persons—instead of the acceptance of the solution there, put here the general recognition, and a moment's reflection will then convince you that the results will not be changed by this substitution. The success which the therapy can have in the individual must also appear in the masses. The patients could not make known their divers neuroses such as their anxious exaggerated love which conceals their hatred, their agoraphobia which tells of disappointed ambitions, their compulsive actions which represent their reproaches for, and safeguards against evil resolutions,—I say they could not bring them to light if their relatives and friends from whom they wish to conceal their psychic processes would know the general meaning of the symptoms. Or if they knew that whatever they produce in their morbid manifestations could really be interpreted by others. But the effect will not confine itself to the concealing of the symptoms,—after all inaccomplishable—for this forced concealment makes the illness inavailable. The communication of the secret attacks the most delicate point of the "etiologic adjustment," which gives origin to the neuroses. What is gained by the disease becomes illusory and hence the only possible result of the changed state of affairs

brought about by the indiscretion of the physician, is a suspension of the morbid production.

If this hope seems to you utopic, please remember that the removal of neurotic symptoms has actually been accomplished in this manner though only in isolated cases. Just think how frequently the hallucination of the Holy Virgin used to occur in former times among peasant girls. As long as such a manifestation drew a large crowd of believers or even resulted in the erection of a chapel over the holy shrine, the visionary state of these girls remained inaccessible to suggestion. Today even the priesthood has changed its attitude towards such manifestations. They allow the doctor and the policeman to visit the visionary girl; consequently the holy virgin seldom reveals herself. Or, allow me to study with you the same process, which I have formerly deferred for the future, in an analogous but lower and more easily observable situation. Let us assume that a circle of ladies and gentlemen of good breeding have agreed upon making a day's excursion to some country place. The ladies have decided among themselves that if one of them should desire to satisfy a natural want she was to say aloud that she is going to pick some flowers. But a mischievous joker discovered this secret and put on the printed program which was sent to those invited: if the ladies wish to ease nature they may say that they are going to pick flowers. Of course, none of the ladies would wish to make use of this covert allusion then, and this also makes impossible the use of any other similar formula. What will be the result? The ladies will admit unabashed their natural wants and the gentlemen will take no offense at it. Let us now return to our more serious case. Because the conflicts of life were too difficult for them so and so many persons have taken refuge in the neuroses and have thereby attained the unmistakable morbid gain, although it is a bit too costly for the time. What will those people be forced to do if the flight into the disease will be closed to them by the indiscrete explanations of psychoanalysis? They will have to be honest and acknowledge the impulses which become active in them, they will have to hold their own in the conflict, they will fight or give up, and the tolerance of society which will inevitably be brought about by psychoanalytic explanation will come to their aid.

However, let us remember that one must not face the world as a fanatical hygienist or therapeutist. Let us admit that this ideal prophylaxis of neurotic diseases will not benefit every individual. A great many of those who today are taking refuge in the disease will not be able to stand the test of the conditions of the conflict postulated by us, they will soon perish or do some mischief greater than their own neurotic disease. The neuroses really have their biological functions. They are protective measures and are justified socially. Their "morbid gain" is not always purely subjective. Who among you has not looked behind the causation of a neurosis and was not forced to admit that the neurosis was the mildest issue of all the possibilities of the situation? And should we really sacrifice so much for the eradication of the neuroses, if the world is filled with other inevitable misery? Should we therefore give up our efforts to explain the secret meaning of the neurosis as being in the end dangerous for the individual and for the workings of society, and should we waive the right of drawing practical conclusions from a fragment of scientific knowledge? No. I believe that notwithstanding all, our duty moves us to another direction. For the morbid gain of the neurosis is on the whole harmful for the individuals and for society. The misfortune that may result in consequence of our explanation work can surely only strike individuals. The return to a more truthful and more worthy state of society will not be too dearly bought at this sacrifice. But above all: all the energies which are now consumed in the production of neurotic symptoms in the service of a phantastic world isolated from reality, all these energies, even if they cannot contribute to the good of the world will nevertheless help to reenforce the cry for that change in our civilization in which alone we see salvation for posterity.

I should therefore like to dismiss you with the assurance that you perform your duty in more than one sense if you treat your patients by psychoanalysis. You not only work in the service of science by making use of the only and never returning opportunity for fathoming the mysteries of neuroses. You not only give the patient for his suffering the most effective treatment now at our disposal, but you also contribute your share to that enlightenment of the multitude from which we expect, indirectly, the most thorough prophylaxis against neurotic diseases.

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